Memorandum

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| To: | Jefferson Health Information Exchange | dba Reliance eHealth Collaborative |
| From: | Kelly T. Hagan | |
| Date: | November 17, 2015 | |
| Subject: | Behavioral Health Information Exchange | |

**I. Introduction**

The sharing of behavioral health information (“**BHI**”) is integral to the operation of new models of health care delivery. This analysis, commissioned by JHIE (Reliance), is meant to address the regulatory challenges posed by conflicting, and in some cases vestigial, federal and state privacy standards for handling BHI.

It is important to be clear at the start about what we will *not* be analyzing. This is not a universal analysis of health information exchange. The focus is strictly on BHI. Moreover, this is not an analysis of all possible exchanges of BHI. Our focus is the exchange of BHI between health care providers. Not between providers and patients. Not between providers and insurers (although we do address relationships within Coordinated Care Organizations (“**CCOs**”). Not between patients and others. Rather, we hope to survey the legal landscape for sharing BHI between health care providers.

The challenges are well-known. Providers confront real or perceived legal obstacles to sharing BHI. The objectives of the Triple Aim are sometimes at odds with privacy regulation implemented long before transformational technologies and strategies made widespread access to patient information a priority in delivering health care. Legislative or regulatory reform is the best response to these obstacles. But until such reform is accomplished, resolving conflicts between privacy and care coordination turns on the creative use of state and federal privacy exceptions, particularly those authorized by 42 CFR Part 2 (“**Part 2**”) and ORS 179.505.

Creative solutions may exceed the regulatory risk tolerance of some providers; the choice among competing compliance strategies must be made by each provider. This is particularly true with respect to Part 2 given that there are criminal fines of up to $5,000 authorized for violation of the Part 2 rules. Our purpose is to present and examine the possibilities.

We proceed first by discussing the principal issues encountered in interpreting privacy protections and their impact on sharing BHI. Second, we examine commonplace scenarios involving patient identifying information subject to Part 2 (“**Part 2 BHI**”), the single greatest obstacle to the sharing of BHI related to drug and alcohol treatment. Third, we examine scenarios involving BHI that is not subject to Part 2. Center stage in that analysis is the interaction of Oregon state law and regulations promulgated under the Health Insurance Portability and Accountability Act (“**HIPAA**”), particularly its privacy provisions (the “**Privacy Rule**”).

We begin by comparing preemption under HIPAA and 42 CFR Part 2.

**A. Preemption**

Two federal authorities are of primary concern with respect to preemption: 45 CFR § 160.203, the HIPAA preemption rule, and 42 CFR § 2.20, the preemption rule for 42 CFR Part 2.

**1. HIPAA**

The HIPAA preemption rule reads as follows:

**§ 160.203 General rule and exceptions.**

A standard, requirement, or implementation specification adopted under this subchapter that is contrary to a provision of State law preempts the provision of State law. This general rule applies, except if one or more of the following conditions is met:

(a) A determination is made by the Secretary under § 160.204 that the provision of State law:

(1) Is necessary:

(i) To prevent fraud and abuse related to the provision of or payment for health care;

(ii) To ensure appropriate State regulation of insurance and health plans to the extent expressly authorized by statute or regulation;

(iii) For State reporting on health care delivery or costs; or

(iv) For purposes of serving a compelling need related to public health, safety, or welfare, and, if a standard, requirement, or implementation specification under part 164 of this subchapter is at issue, if the Secretary determines that the intrusion into privacy is warranted when balanced against the need to be served; or

(2) Has as its principal purpose the regulation of the manufacture, registration, distribution, dispensing, or other control of any controlled substances (as defined in 21 U.S.C. 802), or that is deemed a controlled substance by State law.

(b) The provision of State law relates to the privacy of individually identifiable health information and is more stringent than a standard, requirement, or implementation specification adopted under subpart E of part 164 of this subchapter.

(c) The provision of State law, including State procedures established under such law, as applicable, provides for the reporting of disease or injury, child abuse, birth, or death, or for the conduct of public health surveillance, investigation, or intervention.

(d) The provision of State law requires a health plan to report, or to provide access to, information for the purpose of management audits, financial audits, program monitoring and evaluation, or the licensure or certification of facilities or individuals.

A state law is preempted by HIPAA if it is “contrary to” the Privacy Rule, unless it is “saved” by one of four exceptions: (i) state law determined to be necessary for specified reasons by the Secretary; (ii) state law that is “more stringent” than the Privacy Standards; (iii) state law providing “for the reporting of disease, injury, child abuse, birth or death, or for the conduct of public health surveillance, investigation or intervention”; and (iv) state law governing accessibility to, or the reporting of, information in the possession of health plans. We will not further consider exceptions (i), as the Secretary has not made any such determination to date, or (iv), as we are not concerned with the disclosure of or access to BHI held by insurers. Thus, contrary state law will be preempted unless exception (ii) or (iii) applies.

The analysis is complicated by the definitions of “contrary” and “more stringent.” *See* 45 CFR § 160.202. The definition of “contrary” defines the threshold for preemption. It means *either* (i) it is impossible to comply with both state law and the Privacy Rule, *or* (ii) the state law “stands as an obstacle to the accomplishment and execution of the full purposes and objectives of [the Privacy Rule].” 45 CFR § 160202. An “obstacle” to the Privacy Rule occurs when state law permits, but does not require, confidential treatment of information but the Privacy Rule requires confidentiality. Given the choice created by state law, there is no necessary conflict, but the state law is less protective of privacy than the federal rule and must fall. The definition of “more stringent” sets out six scenarios in which the effect of state law is more protective of privacy, more permissive or more forthcoming with respect to individual access, or more demanding with respect to accounting for disclosures. *Id*.

The other dimension of HIPAA’s relationship to state law is 45 CFR §§ 164.506 and 164.512. These sections provide for exceptions to confidentiality: uses and disclosures for treatment, payment, and healthcare operations; disclosures required by law, disclosures in response to judicial and administrative process; disclosures to law enforcement; and others. In our discussion of BHI disclosure scenarios, we will discuss the application of these provisions more specifically when necessary.

As a general matter, however, HIPAA preemption means that providers must comply with the Privacy Rule in addition to or as modified by more stringent state law requirements (contrary or not). This is the proverbial “patchwork quilt” of more stringent state laws and the privacy “floor” established by the Privacy Rule.

**2. 42 CFR Part 2**

The Part 2 preemption rule is considerably shorter and more unqualified:

**§ 2.20 Relationship to State laws.**

The statutes authorizing these regulations (42 U.S.C. 290ee-3 and 42 U.S.C. 290dd-3) do not preempt the field of law which they cover to the exclusion of all State laws in that field. If a disclosure permitted under these regulations is prohibited under State law, neither these regulations nor the authorizing statutes may be construed to authorize any violation of that State law. However, no State law may either authorize or compel any disclosure prohibited by these regulations.

The punch line is that “no State law may either authorize or compel any disclosure prohibited by these regulations.” The prior sentence mimics HIPAA’s provision giving way to more stringent state law. There is no nuance here. The short version is that, when it comes to Part 2 BHI, state laws requiring disclosure without authorization are preempted, save those regarding cause of death for vital statistics purposes and state-mandated reports of suspected child abuse. 42 CFR §§ 2.15(b)(1), 2.12(c)(6). There are other exceptions to the Part 2 prohibition against disclosure, but they are provided by Part 2, not state law. These exceptions are discussed below.

Largely because of the unqualified preemption provisions of 42 CFR Part 2, the analysis of disclosure scenarios below proceeds in two parts: first, we analyze the sharing of Part 2 BHI, and then second, we analyze the sharing of BHI that is not subject to Part 2. It should come as no surprise that JHIE (Reliance) will have to rely on Part 2 exceptions in order to avoid the requirement of a written patient authorization when disclosure of Part 2 BHI is the issue, and that often the authorization requirement cannot be avoided.

**B. Minors**

Another recurring issue is the authority of minors to control the use and disclosure of their BHI. In the case of Part 2 BHI, 42 CFR § 2.14 provides the answer in nearly all situations: the minor’s written consent is required.

The treatment of other behavioral health information is less clear. The minor’s confidentiality rights vary with state law. With respect to third-party disclosures—that is, disclosures to someone other than the physician or a parent, guardian, or person acting in loco parentis (collectively, a “**parent**”)—the first question is who has the right to control third-party access. Presumptively, parents are considered personal representatives of unemancipated minors and therefore have control over the minor’s protected health information (“**PHI**”) and may authorize disclosures to third parties. [[1]](#footnote-1) There are exceptions to this presumption, however: the parent may agree to a confidential relationship between the practitioner and the minor, or state law grants the minor the power of informed consent and the minor consents to his or her own care. In both cases, control over PHI arising from the minor’s consent, and disclosures to third parties of such PHI, passes to the minor. 45 CFR § 164.502(g)(3)(i).

Even when state law gives minors the power of informed consent, however, and control over disclosures of PHI to third parties passes to the minor, a question remains about a parent’s access to the minor’s PHI. The Office of Civil Rights (“**OCR**”) has said:

In cases in which State or other applicable law is silent concerning parental access to the minor’s protected health information, and a parent is not the personal representative of a minor child based on one of the exceptional circumstances described above, a covered entity has discretion to provide or deny a parent with access under 45 CFR § 164.524 to the minor’s health information, if doing so is consistent with State or other applicable law, and provided the decision is made by a licensed health care professional in the exercise of professional judgment.

“For Covered Entities and Business Associates – Personal Representatives” (revised September 19, 2013). While the OCR guidance cites to 45 CFR § 164.524, the predicate reference would seem to be 45 CFR § 164.502(g)(3)(ii)(A):

(ii) Notwithstanding the provisions of paragraph (g)(3)(i) of this section:

(A) If, and to the extent, permitted or required by an applicable provision of State or other law, including applicable case law, a covered entity may disclose, or provide access in accordance with § 164.524 to protected health information about an unemancipated minor to a parent, guardian, or other person acting in loco parentis.

Where the state law is permissive or mandatory with respect to disclosure to parents, a covered entity retains professional discretion about whether to disclose to parents. For example, ORS 109.675(1) gives minors 14 years of age or older the power of informed consent to treatment of a mental or emotional disorder or a chemical dependency by a physician, psychologist, nurse practitioner, clinical social worker, professional counselor or marriage or family therapist, or a community health program approved by rule to do so by the Oregon Health Authority (“**OHA**”). *See, e.g.*, ORS 430.620. ORS 109.675(2), however, requires parental involvement before the end of treatment absent parental refusal, sexual abuse or the emancipation of the minor. ORS 109.695 directs OHA to adopt rules requiring community mental health programs authorized to do so to provide for “the earliest feasible involvement of parents or guardians in the treatment plan consistent with clinical requirements of the minor.”

The OCR guidance also makes clear its position that, where state law is silent on parental access to a minor’s PHI but the minor may consent to treatment, e.g., ORS 109.610, the same standard of professional judgement applies. Thus, parental access to PHI, as opposed to Part 2 BHI, is usually left to the discretion of the treating practitioner or covered entity even when the minor may consent to treatment.

**C. Psychotherapy Notes**

It is appropriate to briefly discuss the unique status of psychotherapy notes in the Privacy Rule, for two reasons: first, our audience is primarily concerned with BHI; second, in the PHI disclosure scenarios discussed in Sections II and III, below, we will assume unless otherwise stated that psychotherapy notes are not involved. If they are, reference should be made to the specific exceptions from the authorization requirement described in this section.

Psychotherapy notes occupy a singular status under the Privacy Rule as the most closely guarded form of PHI. Practically speaking, they may not be used or disclosed without patient authorization except to carry out treatment, payment, or healthcare operations in three circumstances: (1) by the author of the notes for treatment purposes; (2) for mental health training purposes; or (3) to defend a legal action brought by the subject individual. 45 CFR § 164.508(a)(2)(i); ORS 179.505(17)(b). Additionally, the Privacy Rule provides exceptions for disclosures to the Secretary for compliance investigations, when required by law, when requested by a health oversight agency, to coroners regarding a deceased individual, or to prevent a serious and imminent threat. 45 CFR § 164.508(a)(2)(ii).

**D. Disclosures within Organizations**

As a general rule, the sharing of information within an organization is not a disclosure and is permissible. See 42 CFR § 2.12(c)(3)(i) and 45 CFR § 160.103 (“Disclosure”). However, there are exceptions to the general rule, which we discuss next.

**1. Minimum Necessity**

Sharing or using information within an organization is not unregulated. HIPAA’s minimum necessary requirement restricts access to and use of PHI to that which is minimally necessary to accomplish the intended purpose of the use or disclosure. 45 CFR § 164.502(b). Exceptions to the minimum necessity requirement exist, such as for purposes of treatment. 45 CFR § 164.502(b)(2)(i). Similarly, Part 2 BHI may be communicated within a program if there is a need for the information in connection with job duties arising from the rendering of diagnosis, treatment, or referral for treatment. 42 CFR § 2.12(c)(3)(i).

**2. Segmented Organizations**

The Privacy Rule recognizes that a single legal entity may have divisions within it that perform different functions, some related to the provision of health care and some not. So-called “hybrid” organizations are an example. 45 CFR §§ 164.103, 164.105. “Affiliated Covered Entities” are legally separate but are under common ownership or control; they may declare themselves as a single entity for Privacy Rule purposes. 45 CFR § 164.105. Covered entities may have multiple covered functions, such as a health care provider and a health insurer under the same corporate roof. Sharing between those functionally distinct units of a single organization is a disclosure. 45 CFR § 164.504(g). Finally, a clinically integrated care setting, such as a hospital, where a patient typically receives care from more than one provider, or an organized healthcare system in which multiple covered entities participate and hold themselves out to the public as participating in a joint arrangement and conducting joint activities (e.g., utilization review or quality assessment) may qualify as an “Organized Health Care Arrangement” (“**OHCA**”). Disclosures among participants in an OHCA is permitted without patient authorization, at least those not involving Part 2 BHI.

**E. Part 2 Exceptions**

The prohibition of Part 2 is not unqualified. There are a number of exceptions to the authorization requirement.[[2]](#footnote-2) But the Part 2 exceptions are far fewer, more narrowly drawn, and less familiar. We reserve discussion of exceptions applicable to behavioral information that is not subject to Part 2 for Section III of this memo.

**1. Veterans’ Affairs/Armed Forces**

Part 2 does not apply to information in the hands of the Veterans’ Administration (“**VA**”) and the Armed Forces. 42 CFR § 2.12(c)(1) and (2). Part 2 does not apply to BHI maintained in connection with provision of hospital care, nursing home care, domiciliary care, and medical service benefits provided by the VA. Part 2 does apply to Part 2 BHI in the hands of the Armed Forces and obtained when the patient was a member of the Armed Forces, except uses or disclosures within the Armed Forces, or disclosures between the Armed Forces and the VA concerning the service member’s care by the VA. Unless JHIE (Reliance) participants are contracted agents of the VA, this exception probably does not come into play.

**2. Program or Administrative Entity Personnel**

As discussed in connection with the “minimum necessity” principle, Part 2 BHI may be shared among personnel within a program whose duties create a “need to know” for purposes of diagnosis, treatment, or referral for treatment. 42 CFR § 2.12(c)(2)(i). Additionally, Part 2 BHI may be disclosed between a program’s personnel and personnel of “an entity that has direct administrative control over the program,” if required in connection with job duties arising out of “diagnosis, treatment, or referral for treatment.” 42 CFR § 2.12(c)(2)(ii). We would consider job duties arising from diagnosis, treatment, or referral for treatment to include a broad range of activities, e.g., billing, quality improvement, peer review, etc.

The administrative entity exception is noteworthy in several respects: first, it admits to a certain degree of interpretation. SAMHSA FAQs, while not legally authoritative, use examples of direct administrative control that include effectively any administrative activity to which programs within a “general health care facility” are subject. “General health care facility” encompasses “hospitals, trauma centers, or federally qualified health centers.” “Applying the Substance Abuse Confidentiality Regulations” (“**FAQ II**”), Q10. In order for the program to share Part 2 BHI with other elements of the facility, “administrative controls must be in place to protect Part 2 information if it is shared.” *Id*. SAMHSA goes on in the last paragraph of the answer to FAQ II, Q10 to analogize a general medical facility to a primary care practice with a “unit” or subgroup of practitioners who hold themselves out as providing alcohol and drug treatment, and hence qualify as a “program.” The implication is that the administrative relationship between the alcohol and drug treatment practitioners to the larger primary care practice would meet the direct administrative control test.

This administrative relationship may exist outside a single entity, a facility or a practice group. The SAMHSA FAQs on “Applying the Substance Abuse Confidentiality Regulations to Health Information Exchange (HIE)” (“**HIE FAQ**”) discuss the relationship between “a Part 2 program and an entity that has direct administrative control over the program.” HIE FAQ, Q5. And of course the exception itself distinguishes between disclosures “[w]ithin a program, or [b]etween a program and an entity that has direct administrative control over the program.” 42 CFR § 2.12(c)(3)(i) and (ii). The administrative entity is subject to the restrictions on disclosures contained in 42 CFR § 2.12(d)(2).

The sole case of which we are aware to address the nature of “direct administrative control” involved two separate entities, which was not even a consideration in the analysis. The court found that a state licensing agency did not have direct administrative control over a Part 2 program. *Adolescent & Family Inst. of Colo., Inc. v. Colo. Dep’t of Human Services*, 316 P.3d 316, 2013 COA 44 (Colo. Dec. 9, 2013).

[D]efendant is the government agency with the authority to regulate and license plaintiff. Defendant also has the authority, to some extent, to determine the type and scope of treatment programs that plaintiff administers. However, it is undisputed that defendant has no authority over plaintiff's staffing decisions, internal policy decisions, budget decisions, or management of financial resources, and defendant is not otherwise involved in guiding plaintiff's day-to-day operations.

Therefore, we conclude that defendant is not an entity with direct administrative control over plaintiff and the confidentiality exception of 42 C.F.R. § 2.12(c)(3)(ii) does not apply here.

The Colorado court’s test is clearly demanding, but it is ill-defined. For example, it is not clear whether all of the indicia of control it enumerates must be present for “direct administrative control.” There are demanding legal, contractual, and budgetary relationships within CCOs or Accountable Care Organizations (“**ACOs**”). CCOs or ACOs, or their subcontractors, do prescribe detailed administrative, financial, and management requirements of participants, many of which are required by law, and hold participants accountable for their performance of those requirements. It is arguable that disclosure of Part 2 BHI for these purposes is within the “direct administrative control” exception. Similarly, providers participating in a clinically integrated, or risk-sharing, arrangement may be subject to substantial external control of staffing, policy development, budgetary restraints, and financial management. Is sharing Part 2 BHI for purposes of such administrative controls permissible under the exception?

We know of no definitive answers to these questions, particularly given the near complete absence of case law interpreting 42 CFR § 2.12(c)(3). As we discussed in our RFP, a great deal depends on the risk tolerance of the participant in question. It is clear, however, that the administrative control exercised directly by some healthcare organizations over others, either by contractual agreement or as prescribed by law, far exceeds the licensing agency’s powers in *Adolescent & Family Inst. of Colo., Inc.*, *supra.*

**3. Qualified Service Organizations**

It is permissible to share Part 2 BHI with qualified services organizations (“**QSOs**”) who contract with the program to provide services

such as data processing, bill collecting, dosage preparation, laboratory analyses, or legal, medical, accounting, or other professional services, or services to prevent or treat child abuse or neglect, including training on nutrition and child care and individual and group therapy.

42 CFR § 2.11(“Qualified service organization”). Note the use of the introductory “such as” in this listing of qualified services: the enumerated services are examples; it is not an exhaustive list.

The exception also requires that the services arrangement be memorialized in a writing, a Qualified Service Organization Agreement (“**QSOA**”). Briefly, a QSOA acknowledges Part 2 regulation and obligates the service provider to resist judicial efforts to obtain Part 2 BHI. 42 CFR § 2.12(c)(4).

The interesting aspect of the QSO exception is the open-ended nature of its description, both with respect to its illustrative approach to describing qualified services, and the clear indication that “other” professional services will qualify. We believe that direct contractual relationships between Part 2 providers and other health care professionals for professional services will meet the QSO test and provide a significant work-around for purposes of communicating Part 2 BHI among providers. While redundant contractual relationships would be necessary for those already participating in CCOs or other integrated networks—the exception works only for communication directly between the parties to a QSOA—it may be a desirable alternative to patient consent in many circumstances. It is the only option for direct communication between HIE participants under SAMHSA’s interpretation that an HIE (or presumably anyone not an agent of the recipient) may not redisclose Part 2 BHI to a third party, including other HIE participants. *See* HIE FAQ, Q8.

**4. Child Abuse**

Part 2 does not bar reports of suspected child abuse or neglect under state law. The exception does not extend to the original program records of the patient; it permits only information relevant to the report. *See* 42 CFR § 2.12(c)(6); FAQ II, Q5.

**5. Medical Emergencies**

Part 2 permits the disclosure of information under certain circumstances without consent during a medical emergency or in other limited situations. 42 CFR § 2.51. If a Part 2 program (or a healthcare provider that has received Part 2 patient information) believes that there is an immediate threat to the health or safety of any individual, disclosure and even redisclosure for treatment purposes is allowed:

A Part 2 program can make disclosures to medical personnel if there is a determination that a medical emergency exists, i.e., there is a situation that poses an immediate threat to the health of any individual and requires immediate medical intervention. Information disclosed to the medical personnel who are treating such a medical emergency may be redisclosed by such personnel for treatment purposes as needed.

42 CFR § 2.51(a). 42 CFR 2.51(c) describes the documentation required when a disclosure of identifying information is made in a medical emergency situation: the names of the medical personnel who are the recipients of the disclosure and their affiliation with the subject facility, the name of the person making the disclosure, the date and time of the disclosure, and the nature of the medical emergency.

**6. Personal Representatives**

The identity and authority of personal representatives comes up often in the behavioral health space. Patients may lack capacity at the time they originally seek or receive care or at the time of transitions between care providers. Personal representatives (“**PRs**”) can play important roles at those times. Under both Part 2 and the Privacy Rule, state law plays a large role in defining who may be a PR and when PRs may act on a patient’s behalf, including consent to Part 2 BHI disclosures.

42 CFR § 2.15 addresses PRs in three categories: when the patient has been adjudicated incompetent, when the patient has not been adjudicated incompetent but lacks capacity in the professional judgment of the program director, and when the patient is deceased. You will note that minors are conspicuously absent. *See* 42 CFR § 2.14.

In the first case, the court will have declared the patient incompetent to handle his or her own affairs and appointed a specific person to act as PR. 42 CFR § 2.15(a)(1) gives the court-appointed PR the power to consent on the patient’s behalf in all respects. In the second circumstance, 42 CFR § 2.15(a)(2) permits the director to act as the PR for the limited purpose of consenting to disclosure of Part 2 BHI in order to obtain payment for services from a third party payer. In the third circumstance, where the patient is deceased, 42 CFR § 2.15(b)(1) makes clear that Part 2 does not prohibit communicating facts for vital statistics purposes, such as cause of death. 42 CFR § 2.15(b)(2) applies Part 2 to purposes other than vital statistics. If consent is required, then a PR appointed under applicable state law may consent on the deceased’s behalf. In the absence of an executor or other PR under state law, a spouse or, if there is no surviving spouse, then a responsible family member may consent on behalf of the deceased.

The Privacy Rule also defers to state law with respect to who may act as the patient’s PR. Unlike Part 2, parents are presumptively PRs under the Privacy Rule. That presumption is rebutted, as described above, when the minor exercises the power of informed consent. In other circumstances, such as adult incapacity or the death of a patient, state law governs.

**7. Audit and Evaluation**

Part 2 defines a “third party payer” as follows:

*Third party payer* means a person who pays, or agrees to pay, for diagnosis or treatment furnished to a patient on the basis of a contractual relationship with the patient or a member of his family or on the basis of the patient’s eligibility for Federal, State, or local governmental benefits.

42 CFR § 2.11. Third party payer is not synonymous with “health insurer,” in the sense of an entity licensed by the state to provide health insurance. *See* ORS 731.162. Part 2 uses the term “third party payer” in a broader sense to include any third party who pays, or who has contracted to pay, for health care delivered to another. Governmental health benefit programs are “third party payers” by definition, but they are not state licensed insurers. Presumably ERISA self-insured plans would qualify as third party payers as well. *See* ORS 735.605(10).

Governmental benefit programs often contract with private entities to administer governmental health benefits. Medicare Advantage plans are an example in the Medicare program. CCOs similarly contract with the State of Oregon to deliver services to state Medicaid beneficiaries. These entities would seem to meet the definition of “third party payer” under either prong of the definition: a party contracting to pay for the care of another, or a party who pays or agrees to pay for care furnished “on the basis of the patient’s eligibility for Federal, State, or local governmental benefits.” 42 CFR § 2.53 permits third party payers to inspect Part 2 BHI for “audit or evaluation activity on behalf of [a]ny Federal, State, or local governmental agency which provides financial assistance to the program or is authorized by law to regulate its activities.” 42 CFR § 2.53(a)(1)(i).

42 CFR § 2.53 permits audits or evaluations by “***any person*** who agrees in writing to comply with the limitation on redisclosure and use in paragraph (d) of [42 CFR § 2.53] . . . . . and is determined by the program director to be qualified to conduct the audit or evaluation activities.” 42 CFR § 2.53(a)(2) (emphasis added). Part 2 BHI may be copied and removed from the program’s premises by a qualifying person who agrees to protect the confidentiality and security of such information, to destroy the information upon completion of the audit or evaluation, to comply with restrictions on use and disclosure, and performs the audit or evaluation on behalf of specified parties. Those parties include governmental agencies financially assisting the program or with regulatory authority over the program, a third party payer, or a “quality improvement organization.” 42 CFR § 2.53(b)(2)(i) and (ii).

**F. Application of ORS 430.399 and 179.505**

The state has effectively two sets of statutes and rules applicable to disclosure of drug and alcohol treatment information. ORS 430.397 and 430.399 by their terms apply to a “treatment facility operated pursuant to rules of the Oregon Health Authority.” ORS 430.397. A “treatment facility” includes:

outpatient facilities, inpatient facilities, and other facilities the [Oregon Health Authority] determines suitable and that provide services that meet minimum standards established under ORS 430.357, any of which may provide diagnosis and evaluation, medical care, detoxification, social services or rehabilitation for alcoholics or drug-dependent persons and which operate in the form of a general hospital, a state hospital, a foster home, a hostel, a clinic or other suitable form approved by the [Oregon Health Authority].

ORS 430.306(9).

The confidentiality rule applicable to such facilities is ORS 430.399(6), which is more unqualified in its prohibition of disclosure than Part 2:

The records of a person at a treatment facility or sobering facility may not, without the person’s consent, be revealed to any person other than the director and staff of the treatment facility or sobering facility. A person’s request that no disclosure be made of admission to a treatment facility or sobering facility shall be honored unless the person is incapacitated or disclosure of admission is required by ORS 430.397.

Oregon Laws 2015, Ch. 730, Section 4 (amending ORS 430.399 and effective July 20, 2015).

The other statute is ORS 179.505, which governs “health care services providers” employed by or contracted with “public providers.” ORS 179.505(1)(b). The text of ORS 179.505 is several pages long, so I will not reproduce it here. The definition of “public provider” was amended in the 2015 session to include the “foundational capabilities and programs” enumerated in Oregon Laws 2015, Ch. 736, Sections 9 to 24 (HB 3100), which brings a wide range of public health programming under the direction of the Oregon Health Authority (“**OHA**”), but does not appear to specifically address alcohol and drug programs or to suggest that all public alcohol and drug treatment programs are thereby subject to ORS 430.397 or 430.399. Further legislative history research concerning this legislation may suggest a different conclusion.

The unqualified prohibition of ORS 430.399(6) would seem to be limited to health care facilities, such as hospitals or residential treatment facilities, approved by the OHA, and where inpatient, long-term, or continuing outpatient care is provided. This, at any rate, has been the assumption among health care providers and their legal counsel, at least in part to avoid the unqualified prohibition of ORS 430.399(6) and the obstacles broader application would entail. *See* *Health Law in Oregon*, § 3.14-1(a) (OSB CLE 2014).

**II. Part 2 BHI**

While by no means exhaustive, the preceding discussion makes it possible to refer to certain concepts or issues without going into detail. Hopefully, this will streamline our analysis of common scenarios or categories of disclosures in which Part 2 BHI could potentially play a role.

As outlined in our RFP, we are primarily concerned with the nature of the information (in this Section II, Part 2 BHI), the nature of the disclosing party, the nature of the recipient, and the purpose of the disclosure. From these assumptions we identify the controlling law and apply it to the disclosure described by the scenario. We also assume that any state funded or contracted alcohol and drug treatment program or facility is subject to Part 2. We avoid discussion of the exceptions well-described in Part 2, such as court orders, which are rarely involved in the principal concern of the analysis: the coordination of services among health care providers.

It should be said upfront, however, that the default rule under Part 2 is that disclosures require the patient’s consent. Most of what follows are examples of circumstances that may deviate from that default rule.

**A.** **Disclosing Party**: Part 2 Program

**1. Recipient**: Behavioral Health Provider

**a. Purpose**: Treatment, Same Program

* **Preemption**: 42 CFR § 2.20 preempts any state law that either authorizes or compels any disclosure prohibited by Part 2 without patient consent. One of the exceptions to the Part 2 prohibition is communication between personnel “within a program” and who have a need to know Part 2 BHI. 42 CFR § 2.12(c)(3). ORS 430.397 requires notification to the parents of a minor who voluntarily admits him- or herself to a facility subject to ORS 430.399. Parental notification would be preempted under 42 CFR § 2.14.

If the provider is not subject to ORS 430.399, then the relevant state law would need to be as or more stringent than Part 2, as is the case with OAR 415-02-0020 (opioid treatment program). Otherwise, state law permitting or requiring disclosure prohibited by Part 2 is pre-empted. This would include disclosures authorized by ORS 192.561 and 414.679.

The examples of “direct administrative control” provided by SAMHSA approve the sharing of information with other divisions or service lines within a single entity, such as a hospital or an FQHC. See FAQ II, Q10.

* **Disclosure permissible?** Yes, disclosures are permissible to personnel with a need to know within the program. 42 CFR § 2.12(c)(3); ORS 430.399(6). OAR 415-020-0020 follows the federal rule with regard to opioid treatment programs.

**b. Purpose**: Treatment, Outside the Program

* **Preemption**: 42 CFR § 2.20 preempts any state law that either authorizes or compels any disclosure prohibited by Part 2 without patient consent. 45 CFR § 160.203 is unlikely to come into play, as it does not distinguish Part 2 BHI from any other form of PHI, save in the form of psychotherapy notes. While ORS 192.561 and 414.679 expressly supersede ORS 179.505, Part 2 preempts state law permitting or requiring disclosures that it prohibits.
* **Disclosure permissible?** No. Disclosing Part 2 BHI outside the program is impermissible without the patient’s authorization, even for treatment purposes for a shared patient, absent an authorization or an applicable exception. 42 CFR § 2.13(a).

**2. Recipient**: Emergency Medical Personnel

**a. Purpose**: Treatment of Immediate Threat to Health

* **Preemption**: 42 CFR § 2.20 preempts any state law that either authorizes or compels any disclosure prohibited by Part 2 without patient consent. But Part 2 permits disclosure of patient identifying information to medical personnel for treatment of a condition that poses an immediate threat to the health of any individual and which requires immediate medical intervention. 42 CFR § 2.51(a).
* **Disclosure Permitted?** Only under the stated exceptional circumstances. Interestingly, the exception for medical emergencies refers to an immediate threat to the health of “any individual,” not just the patient’s. One can imagine relevant genetic or hereditary information about a patient, or a medical condition, communicable disease, or other health information about the patient that would be relevant to emergent treatment of another individual.

Note also the disclosure documentation requirements set forth in 42 CFR § 2.51(c).

**3. Recipient**: Health Care Facility or Professional

**a. Purpose**: Treatment, Diagnosis, Diagnostic Tests, Drug Dispensing

* **Preemption**:42 CFR § 2.20 preempts any state law that either authorizes or compels any disclosure prohibited by Part 2 without patient consent. ORS 414.397, 414.399, and 430.401 (as amended by Oregon Laws 2014, Ch. 45, Section 47), which purport to immunize licensed providers (and others) from criminal prosecution, would be preempted unless an exception applies.
* **Disclosure Permitted?** Only in the circumstance described by an exception and, with respect to the QSOA exception, in “other” similar service arrangements. *See* section I.E.3, above. The “direct administrative control” exception is potentially applicable, particularly to programs within a “general health care facility.” The QSOA exception would permit disclosure of patient identifying information to professional service providers under a compliant contract arrangement. *See* 42 CFR § 2.11(b).

**4. Recipient**:CCO

**a. Purpose**: Audit and Evaluation

* **Preemption**: 42 CFR § 2.20 preempts any state law that either authorizes or compels any disclosure prohibited by Part 2 without patient consent. There is no exception to the authorization requirement for submission of claims or the like; submission of identifiable claims information requires the consent of the patient or the patient’s PR. But Part 2 does make provision for private parties conducting auditing and evaluation activities like those performed by a federal health care program:

[I]f a private organization provides financial assistance to a program, is a third party payer covering patients in the program, or is a peer review organization performing a utilization or quality control review, the Final Rule permits the private organization to have access to patient identifying information for the purpose of participating in audit and evaluation activities to the same extent and under the same conditions as a governmental agency.

52 Fed. Reg. 21796, 21801 (June 9, 1987).

* **Disclosure Permitted**? Yes, but only for purposes of audit and evaluation by a private organization that provides financial assistance to a program, is a third party payer covering patients in the program, or is a peer review organization performing a utilization or quality control review.

*Third party payer* means a person who pays, or agrees to pay, for diagnosis or treatment furnished to a patient on the basis of a contractual relationship with the patient or a member of his family or on the basis of the patient’s eligibility for Federal, State, or local governmental benefits.

42 CFR § 2.11. You will note that the definition of “third party payer” does not require state licensure as an insurer. Governmental health benefit programs are “third party payers,” but they are not licensed insurers. *See* *also* 45 CFR § 160.103 (“health insurance issuer” and “health plan”). Likewise, private organizations, such as CCOs or ERISA self-insured health plans, are obligated by contract to pay for care. We would argue that all such contractual payers are permitted to audit and evaluate as permitted by the exception.

While Part 2 does not address the status of agents or subcontractors of a third party payer for audit and evaluation purposes, there is an argument to be made that subcontractors of a CCO that are charged with fiscal control of providers further downstream are acting as the CCO’s agent for purposes of audits and evaluations. This is analogous to the interplay of Health Information Organizations and their subcontractors under the QSAO exception.

An HIO may disclose the Part 2 information to a contract agent of the HIO, if it needs to do so in order to provide the services described in the QSOA, and as long as the agent only discloses the information back to the HIO or the Part 2 program from which the information originated. If a disclosure is made by the HIO to an agent acting on its behalf to perform the service, both the HIO and the agent are bound by Part 2, and neither organization can disclose the information except as permitted by Part 2.

HIE FAQ, Q10. If reliance on an “agency” theory of subcontracted audit and evaluation does not appeal, then a QSOA could be put in place between Part 2 programs and upstream participants in the CCO who will be performing auditing and evaluation functions.

Note that 42 CFR § 2.12(d)(2) makes third party payers subject to the restrictions of Part 2 when receiving individually identifiable patient information. Redisclosure to third parties is prohibited. *Id*.

**5. Recipient**:Fellow CCO Member

**a. Purpose**: Coordination of Care

* **Preemption**: 42 CFR § 2.20 preempts any state law that either authorizes or compels any disclosure prohibited by Part 2 without patient consent. ORS 192.561 and 414.679 (as amended by Oregon Laws 2015, Ch. 389, Section 11) purport to authorize or require disclosure of Part 2 BHI among provider participants in the CCO. These state statutes fall to Part 2’s preemption provision.
* **Disclosure Permitted?** Generally no, unless an exception applies. As suggested above, a direct QSOA relationship between the program and other CCO members is such an exception. The QSOA may be redundant of some obligations contained in the CCO participation agreement, but that does not mean they do not qualify for the exception. It bears repeating though that the Part 2 program may only disclose information necessary for the QSO to perform its duties under the QSOA. FAQ II, Q3.

It also may be that upstream members of the CCO are in positions of administrative responsibility that meet the “direct administrative control” test and the accompanying exception. But bear in mind that this exemption is fact-intensive in its application and, given little guidance from the agencies or the courts, does involve a significant degree of regulatory risk.

**6. Recipient**:Qualified Service Organization

**a. Purpose**: Rendering Qualifying Services

* **Preemption**: 42 CFR § 2.20 preempts any state law that either authorizes or compels any disclosure prohibited by Part 2 without patient consent.
* **Disclosure Permitted?** Generally yes, if the Part 2 BHI is needed to render the qualifying services. 42 CFR § 2.12(c)(4). A QSOA relationship is an exception to the Part 2 prohibition. The terms of the QSOA must meet Part 2 requirements. 42 CFR § 2.11 (“Qualified service organization”).

**B.** **Disclosing Party**: Behavioral Health Provider

**1. Recipient**: Behavioral Health Provider

**a. Purpose**: Treatment, Same Program

* **Preemption**: 42 CFR § 2.20 preempts any state law that either authorizes or compels any disclosure prohibited by Part 2 without patient consent. One of the exceptions to the Part 2 prohibition is communication between personnel “within a program” and which have a need to know Part 2 BHI. 42 CFR § 2.12(c)(3). It also is true that a single provider or a group of providers may constitute a “program” under the definitions of 42 CFR § 2.11, so the analysis may be similar to the one given under Section II.A., above.
* **Disclosure permissible?** Yes, disclosures are permissible to personnel with a need to know within a program. 42 CFR § 2.12(c)(3); ORS 430.399(6).

**b.** **Purpose**: Treatment, Outside the Program

* **Preemption**: 42 CFR § 2.20 preempts any state law that either authorizes or compels any disclosure prohibited by Part 2 without patient consent. While ORS 192.561 and 414.679 expressly supersede ORS 179.505, Part 2 preempts state law permitting or requiring disclosures that it prohibits.
* **Disclosure permissible?** No. Disclosing Part 2 BHI outside the program is impermissible without the patient’s authorization, even for treatment purposes for a shared patient, absent an applicable exception. 42 CFR § 2.13(a).

**2. Recipient**: Emergency Medical Personnel

**a. Purpose**: Treatment of Immediate Threat to Health

* **Preemption**: 42 CFR § 2.20 preempts any state law that either authorizes or compels any disclosure prohibited by Part 2 without patient consent. But Part 2 permits disclosure of patient identifying information to medical personnel for treatment of a condition that poses an immediate threat to the health of any individual and which requires immediate medical intervention. 42 CFR § 2.51(a).
* **Disclosure Permitted?** Only under the stated exceptional circumstances. As noted above, the exception refers to an imminent threat to the health of “any individual,” not just the patient’s. Identifiable information about the patient may be relevant to another person’s emergent care, but could only be disclosed in that limited situation. Note also the documentation requirements for disclosure set forth in 42 CFR § 2.51(c).

**3. Recipient**: Health Care Facility or Professional

**a. Purpose**: Treatment, Diagnosis, Lab Tests, etc.

* **Preemption**:42 CFR § 2.20 preempts any state law that either authorizes or compels any disclosure prohibited by Part 2 without patient consent. ORS 414.397 and 414.399 would be preempted unless an exception applies. ORS 430.401 (as amended by Oregon Laws 2014, Ch. 45, Section 47), which purports to immunize licensed providers (and others) from criminal prosecution, also would be preempted unless an exception applies.
* **Disclosure Permitted?** Not unless an exception applies. With respect to the QSOA exception, a compliant agreement is necessary for the enumerated or “other” similar service arrangements. *See* Section I.E.3, above, *also* 42 CFR § 2.11(b). The “direct administrative control” exception is potentially applicable, particularly to programs within a “general health care facility.” Administrative safeguards would need to be in place and followed if disclosing to a healthcare professional within the facility but outside the “program.”

**4. Recipient**:CCO

**a. Purpose**: Audit and Evaluation

* **Preemption**: 42 CFR § 2.20 preempts any state law that either authorizes or compels any disclosure prohibited by Part 2 without patient consent. As noted above, Part 2 does make provision for auditing and evaluation activities like those performed by a federal health care program. *See* 52 Fed. Reg. 21796, 21801 (June 9, 1987).
* **Disclosure Permitted?** Yes, but only for purposes of audit and evaluation by a party identified in 42 CFR § 2.53. As discussed above in Section I.E.7, licensure as an insurer is not an element of the definition of “third party payer.” A CCO is obligated by contract to pay for the care rendered to another, and should qualify as a third party payer for that reason. In any event, presumably the CCO would be deemed qualified by the program director. 42 CFR § 2.53(a)(2).

Administration of monies passed through the CCO is often performed by its subcontractors. The status of agents of the CCO for audit and evaluation purposes is arguably analogous to the subcontractor discussed in HIE FAQ, Q10. But in any event, a parallel QSOA should provide a basis for downstream CCO participants to perform audit and evaluation functions.

Again, note that 42 CFR § 2.12(d)(2) makes third party payers subject to the restrictions of Part 2 when receiving individually identifiable patient information.

**5. Recipient**:Fellow CCO Participant

**a. Purpose**: Coordination of Care

* **Preemption**: 42 CFR § 2.20 preempts any state law that either authorizes or compels any disclosure prohibited by Part 2 without patient consent. ORS 192.561 and 414.679 (as amended by Oregon Laws 2015, Ch. 389, Section 11) purport to authorize or require disclosure of Part 2 BHI among provider participants in the CCO. These state statutes are preempted.
* **Disclosure Permitted?** Generally no, unless an exception applies. As suggested above, a direct QSOA relationship between the provider and other CCO participants for purposes of rendering professional services is such an exception. The QSOA may run parallel to CCO agreements, but the parties to the QSOA have obligations that are additional to those outlined in the CCO participation agreement. The QSOA permits the disclosure of Part 2 BHI to other CCO members only to the extent necessary for the QSO to perform its duties under the QSOA. FAQ II, Q3. To the extent upstream CCO members are in positions of administrative responsibility, it may be that the administrative entity exception applies. These exceptions, particularly the “direct administrative control” test, are fact-intensive in their application and do involve a degree of regulatory risk.

**C. Disclosing Party**: Health Care Facility or Professional

**1. Recipient**: Behavioral Health Provider

**a. Purpose**: Treatment, Same Program

* **Preemption**: 42 CFR § 2.20 preempts any state law that either authorizes or compels any disclosure prohibited by Part 2 without patient consent. One of the exceptions to the Part 2 prohibition is communication between personnel “within a program” and having a need to know Part 2 BHI. 42 CFR § 2.12(c)(3).
* **Disclosure permissible?** Possibly. As a threshold matter, if the health care facility or professional is not a “program” as defined in Part 2, then it is not subject to Part 2. However, if the facility or professional obtained Part 2 BHI because it exercises “direct administrative control” of a program, or received it under a QSOA, then it is subject to Part 2’s prohibition against redisclosure. 42 CFR § 2.12(d)(2)(ii). If the recipient is part of the program over which the disclosing party exercises direct administrative control, or the disclosing party and the recipient are parties to a QSOA, then Part 2 BHI may be disclosed if needed.

In a non-emergency situation, if the health care provider concerned about a potential drug interaction is part of the Part 2 program (or of an entity that has direct administrative control over the program), he or she can gain access to the Part 2 patient’s record without consent if the health care provider needs the information to treat the patient. 42 CFR § 2.12(c)(3) does not restrict communications ***between and among*** such personnel who have a need for the information in connection with their duties arising out of the provision of diagnosis, treatment or referral for treatment services.

FAQ II, Q9 (emphasis added).

**2. Recipient**: Behavioral Health Provider

**a. Purpose**: Treatment, Different Program

* **Preemption**: 42 CFR § 2.20 preempts any state law that either authorizes or compels any disclosure prohibited by Part 2 without patient consent.
* **Disclosure permissible?** As a threshold matter, if the health care facility or professional is not a “program” as defined in Part 2, then it is not subject to Part 2. Assuming the disclosing party is a program, then an exception is necessary. The recipient description forecloses the “direct administrative control” exception, at least on the basis of the disclosing and receiving parties being part of the same facility. An upstream contractor in a CCO or some other responsible party conceivably could qualify under the “direct administrative control” exception. If the health care facility or professional obtained Part 2 BHI under a QSOA, then the facility or provider may disclose Part 2 BHI back to the program if disclosure is needed. 42 CFR § 2.12(c)(4).

**3. Recipient**: Emergency Medical Personnel

**a. Purpose**: Treatment of Immediate Threat to Health

* **Preemption**: 42 CFR § 2.20 preempts any state law that either authorizes or compels any disclosure prohibited by Part 2 without patient consent. As a threshold matter, if the licensed facility or professional is not a “program” as defined in Part 2, then it is not subject to Part 2.

But Part 2 permits disclosure of patient identifying information to medical personnel for treatment of a condition that poses an immediate threat to the health of any individual and which requires immediate medical intervention. 42 CFR § 2.51(a).

* **Disclosure Permitted?** Yes. Putting aside the question of how the facility or provider came into possession of the Part 2 BHI, 42 CFR § 2.51(a) permits disclosure in emergent situations when disclosure is needed. Period. Note also the documentation requirements for disclosure set forth in 42 CFR § 2.51(c).

**III. Behavioral Health Information**

The analysis of Part 2 is relatively straightforward: either patient consent is obtained, or reliance must be placed on one of the limited exceptions spread throughout Part 2. Not so with other behavioral health information. That is, information that is not Part 2 BHI. We address in this section III behavioral health information (“**BHI**”) that encompasses primarily records of mental health and developmental disability services. Before doing so, however, we outline the structure and discuss the most commonly encountered issues in ORS 179.505.

**Structure of ORS 179.505**

ORS 179.505 is directed to “public providers” and the “health care services providers” that contract with them. ORS 179.505(1)(g) and (b), respectively. Given the state and local role in behavioral health, most of the state’s mental health providers are swept up in ORS 179.505. The records protected by ORS 179.505 are described as “written accounts,” which contain “only individually identifiable health information.” ORS 179.505(1)(h).

ORS 179.505(3) provides for written authorization for disclosure by the patient or the patient’s personal representative, which must contain specified information. 179.505(3)(a). A “personal representative” may be an appointee under a number of state statutes cited in ORS 179.505(1)(d), but “is not limited to” such appointed persons. It is likely that other persons, such as parents, persons acting in loco parentis, or persons appointed under the laws of a different state, should be treated as “personal representatives.”

Access or disclosures of BHI without patient consent are authorized by the subsections listed in ORS 179.505(2), “or unless otherwise permitted or required by state or federal law or by order of the court.” *Id*. A new subsection (18) was added by the 2015 Oregon Legislature. 2015 Oregon Laws, Ch. 473, Section 3 (effective June 18, 2015). ORS 179.505(18) permits disclosures in an ethical exercise of professional judgment for the protection of any person or the public.

**Interpreting ORS 179.505(2)**

There are conflicting schools of thought on the interpretation of the first sentence of ORS 179.505(2), which begins by describing the exceptions to the statute’s prohibition against disclosure, and then stating the prohibition.

(2) Except as provided in subsections (3), (4), (6), (7), (8), (9), (11), (12), (14), (15), (16), (17), and (18) of this section or unless otherwise permitted or required by state or federal law or by order of the court, written accounts of the individuals served by any health care services provider maintained in or by the health care services provider by the officers or employees thereof who are authorized to maintain written accounts within the official scope of their duties are not subject to access and may not be disclosed.

The controversy concerns whether the cited subsections of ORS 179.505 or the permissions and requirements of state or federal law control. That is, are the state exceptions and the other state and federal law additive or alternative? The “more specific” camp holds that the exceptions recited in subsection (2) are “more specific” to the subject matter of ORS 179.505 and therefore should control. The “expansive” reading of subsection (2) relies on a grammatical analysis and questions the purpose of the second clause (“or unless otherwise permitted or required by state or federal law”) if it is not to import these additional provisions of law.

No Oregon case has decided the issue. We note that the legislature has enacted new laws, most recently with respect to CCOs, that begin with a prefatory phrase, “Notwithstanding ORS 179.505,” that would not seem to be necessary if the expansive interpretation of ORS 179.505(2) was correct. But what meaning then do we give to the reference to state and federal law? Basic statutory construction principles provide “where there are several provisions or particulars such construction is, if possible, to be adopted as will give effect to all.” ORS 174.010. On the other hand, “a particular intent controls a general intent that is inconsistent with the particular intent.” ORS 174.020.

On balance, the more conservative advice is to give the specific provisions of ORS 179505(2) controlling authority when a “health care services provider” is under contract with a “public provider.” ORS 179.505(1)(b) and (g). When private services are at issue, reliance on more liberal provisions of state and federal law may be taken. The first scenario illustrates this reasoning, as well as the broader range of exceptions available from other state and federal law.

**ORS 179.505(14) Prohibits Redisclsoure**

ORS 179.505 contains a prohibition against redisclosure of BHI obtained under the statute. ORS 179.505(14). ORS 179.505(14) permits redisclosure only in compliance with ORS 179.505(2).[[3]](#footnote-3) Unlike HIPAA, which regulates PHI only in the hands of covered entities or business associates, the redisclosure prohibition in ORS 179.505(14) applies to anyone receiving BHI in compliance with that section. Interestingly, like 42 CFR Part 2, the resdisclsoure prohibition would apply even to persons receiving BHI by patient authorization, but there is no notice of the redisclosure prohibition required to accompany the BHI disclosed under ORS 197.505.

**HIPAA Exception: Uses and Disclosures “Required by Law”**

45 CFR § 164.512(a) states an exception to HIPAA’s authorization requirement: uses or disclosures “required by law.” Other HIPAA exceptions are required by state law – *e*.*g*., mandatory public health reporting, discovery of health care records in legal actions, etc. – but the “required by law” exception is a catchall for state or federal mandatory disclosures. Thus, unlike 42 CFR Part 2, contrary state law is not preempted if it states a mandatory rule of disclosure. *See*, *e*.*g*., ORS 192.561(a). A permissive state statute does not satisfy the exception; *e*.*g*., ‘a health care provider ***may*** disclose . . .”.

With this background on ORS 179.505, and the “required by law” exception of HIPAA, we proceed to address use scenarios for BHI that is **not** covered by 42 CFR Part 2.

**A.** **Disclosing Party**: Health Care Service Provider

**1. Recipient**: Health Care Facility or Provider

**a. Purpose**: Non-emergent Treatment

* **Preemption**: HIPAA preempts state law if it is “contrary to” the Privacy Rule unless it is “saved” by an exception to the preemption provision. ORS 179.505(4)(a) provides for disclosure by a “health care service provider” in the event of a “medical emergency.” This would be contrary to the more general provisions of 45 CFR § 164.506(c)(2), which permits a covered entity to disclose PHI to a health care provider for treatment purposes. 45 CFR § 164.502(b)(2) permits disclosure for treatment activities of a health care provider even if not “minimally necessary” for the intended purpose. But being “more stringent” than the federal Privacy Rule, the contrary provision of ORS 179.505 (4)(a) would be saved from preemption.

More difficult to evaluate is ORS 179.505(6). It allows an individual’s records to be transferred, when necessary or beneficial to the individual’s treatment, to providers of the Oregon Health Authority, the Department of Corrections, or a local correctional facility. “[A] provider currently engaged in the treatment of an individual” may release records to the provider’s officers, employees, agents, or cooperating providers. Those recipients, in turn, must be acting within the official scope of their duties “to evaluate treatment programs, to diagnose or treat or to assist in diagnosing or treating an individual when the written account is to be used in the course of diagnosing or treating the individual.” ORS 179.505(6). While somewhat more difficult to follow, ORS 179.505(6) is nonetheless “more stringent” than the blanket permission offered by 45 CFR § 164.506(c)(2).

For private behavioral health providers, ORS 192.558(3)(b) would permit the same disclosure as the federal Privacy Rule.

* **Disclosure Permitted**? Yes, but only to the extent permitted by ORS 179.505(4)(a) and (6).

**b. Purpose**: Medical Emergency

* **Preemption**: HIPAA preempts state law if it is “contrary to” the Privacy Rule unless it is “saved” by an exception to the preemption provision. ORS 179.505(4)(a) permits disclosure “to any person to the extent necessary to meet a medical emergency.” So too does the Privacy Rule. 45 CFR § 164.506(c)(2).
* **Disclosure Permitted?** Yes.

**c. Purpose**: Threat to Health or Safety of a Person or the Public

* **Preemption**: HIPAA preempts state law if it is “contrary to” the Privacy Rule unless it is “saved” by an exception to the preemption provision. 45 CFR § 164.512(j) permits disclosure “if the covered entity, in good faith, believes the use or disclosure . . . [i]s necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and . . . is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat . . .” This would be the standard applicable to a private provider, as there is no comparable state statute.

ORS 179.505(12) provides:

Information obtained in the course of diagnosis, evaluation or treatment of an individual that, in the professional judgment of the health care services provider, indicates a clear and immediate danger to others or to society may be reported to the appropriate authority. A decision not to disclose information under this subsection does not subject the provider to any civil liability. Nothing in this subsection may be construed to alter the provisions of [reporting requirements for injuries from deadly weapons or potential child abuse].

* **Disclosure Permitted**? Yes, to the extent permitted by ORS 179.505(12). For private providers, the standard in 45 CFR § 164.512(j) would be applicable:

A covered entity may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, if the covered entity, in good faith, believes the use or disclosure:

(i)(A) Is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and

(B) Is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat[.]

Note that both state and federal law in this circumstance are permissive rather than mandatory. With the exception of disclosures to the Secretary or the individual, no disclosure authorized by the Privacy Rule is mandatory. In this case, neither are the provisions of 2015 Oregon Laws, Ch. 473, Section 3, or ORS 179.505(12).

We are reminded of the holding in *Tarasoff v. Regents of the University of California*, 551 P.2d 334 (1976), a decision of the California Supreme Court. While not binding in Oregon, the *Tarasoff* court’s “duty to warn” reasoning based on a provision of the California Evidence Code has been influential. *See, e.g.*, Code of Medical Ethics of the American Medical Association, § 5.05.

**d. Purpose**: Disclosure of Psychotherapy Notes

* **Preemption**: HIPAA preempts state law if it is “contrary to” the Privacy Rule unless it is “saved” by an exception to the preemption provision. Psychotherapy notes are notes recorded by “a mental health professional, in the performance of official duties” that document or analyze contents of conversation during a counseling session, and that are “maintained separately from the rest of the individual’s record.” ORS 179.505(1)(e). This definition is taken from the federal Privacy Rule. 45 CFR § 164.501 (“Psychotherapy notes”). Access and disclosure of psychotherapy notes generally requires specific authorization. ORS 179.505(17)(a). A provider may access or disclose psychotherapy notes without authorization for the provider’s own treatment purposes, for the provider’s own training program, or to defend the provider in a legal action. ORS 179.505(17)(b). This is taken verbatim from the Privacy Rule, 45 CFR § 164.508(a)(2).
* **Disclosure Permitted**? Yes, to the extent permitted by ORS 179.505(17)(b).

**e. Purpose**: Health Care Operations

* **Preemption**: HIPAA preempts state law if it is “contrary to” the Privacy Rule unless it is “saved” by an exception to the preemption provision. Under ORS 179.505(4)(b), records may be disclosed for “scientific research, program evaluation, peer review, and fiscal audits.” Patient identities are not to be revealed unless necessary. The definition of “health care operations” in 45 CFR § 164.501 is considerably broader, the result being that the state law is “more stringent” and therefore saved from preemption.
* **Disclosure Permitted**? Yes, to the extent permitted by ORS 179.505(4)(b). Documentation requirements for disclosure are outlined in ORS 179.505(5).

Private providers are able to disclose PHI for a much broader scope of health care operations. ORS 192.556(4). 45 CFR § 164.501.

**2. Recipient**:CCO

**a. Purpose**: Payment

* **Preemption**: HIPAA preempts state law if it is “contrary to” the Privacy Rule unless it is “saved” by an exception to the preemption provision. ORS 179.505(4)(c) permits disclosure to governmental agencies for payment purposes, but a CCO is not a governmental agency. ORS 192.561(1)(a) provides, however, “[n]otwithstanding ORS 179.505,” that a health care provider “shall disclose protected health information” to the CCO for “payment purposes” as permitted by ORS 192.558(1)(a). This is not contrary to 45 CFR § 164.506(c)(1), and is “required by law.” 45 CFR § 164.512(a).

When private providers seek payment, ORS 192.558(2)(a) permits disclosure for a provider’s own payment purposes, as does 45 CFR § 164.506(1).

* **Disclosure Permitted**? Yes.

**b. Purpose**:Health Care Operations (including coordination of care).

* **Preemption**: HIPAA preempts state law if it is “contrary to” the Privacy Rule unless it is “saved” by an exception to the preemption provision. ORS 179.505(4)(b) permits disclosure for “scientific research, program evaluation, peer review, and fiscal audits.” Patient identities are not to be revealed unless necessary. ORS 192.579(2) provides that, “[n]otwithstanding ORS 179.505,” an “entity,” defined to include a health care provider and a CCO, ***may*** share protected health information with another entity for coordination of care purposes. Oregon Laws 2015, Ch. 792, Section 4. Being permissive, 45 CFR § 164.512(a) does not give way to the state statute. “Health care operations,” as defined in ORS 192.556(4), include “[c]ase management and care coordination.” ORS 192.556(4)(b). Moreover, ORS 179.505(6) permits the sharing of information between “health care services providers” to assist in the diagnosing or treatment of individuals.

The Privacy Rule permits disclosure for health care operations, which includes 45 CFR § 164.502(a)(1)(ii), *but only between two covered entities (or a covered entity and a business associate) and only when they have a common patient*. 45 CFR § 164.506(c)(4) provides:

A covered entity may disclose protected health information to another covered entity for health care operations activities of the entity that receives the information, if each entity either has or had a relationship with the individual who is the subject of the protected health information being requested, the protected health information pertains to such relationship, and the disclosure is:  
(i) For a purpose listed in paragraph (1) or (2) of the definition of health care operations [which includes “case management and care coordination”]; or   
\* \* \* \* \*   
(5) A covered entity that participates in an organized health care arrangement may disclose protected health information about an individual to other participants in the organized health care arrangement for any health care operation activities of the organized health care arrangement.

Is a CCO a “covered entity?” As a practical matter, a CCO would have to qualify as either a health care provider or a health plan, as defined by 45 CFR § 164.103. As between the two terms, “health care provider” would seem a better fit: “any . . . person who furnishes, bills, or is paid for health care in the normal course of business.” 45 CFR § 164.103.

If CCOs are not a health care provider or health plan, then we need to find another HIPAA entity that may receive information for health care operation purposes. One possibility is that a CCO qualifies as a participant in an “organized health care arrangement” (“**OHCA**”). A “participant,” an undefined term, in an OHCA may receive PHI for health care operation purposes from another participant in the OHCA. 45 CFR § 164.506(c)(5). An OHCA is defined in 45 CFR § 160.103:

Organized health care arrangement means:

(1) A clinically integrated care setting in which individuals typically receive health care from more than one health care provider;

(2) An organized system of health care in which more than one covered entity participates and in which the participating covered entities:

(i) Hold themselves out to the public as participating in a joint arrangement; and

(ii) Participate in joint activities that include at least one of the following:

(A) Utilization review, in which health care decisions by participating covered entities are reviewed by other participating covered entities or by a third party on their behalf;

(B) Quality assessment and improvement activities, in which treatment provided by participating covered entities is assessed by other participating covered entities or by a third party on their behalf; or

(C) Payment activities, if the financial risk for delivering health care is shared, in part or in whole, by participating covered entities through the joint arrangement and if protected health information created or received by a covered entity is reviewed by other participating covered entities or by a third party on their behalf for the purpose of administering the sharing of financial risk.

\* \* \* \* \*

The remainder of the OHCA definition involves health plans. Among the choices presented in subsections (1) and (2), subsection (2) seems to describe a CCO best.

Finally, a CCO could be considered a “business associate” for purposes of 45 CFR § 164.502(a)(3). If so, then sharing information for health care operation purposes is permissible for either “the proper management and administration of the [CCO],” 45 CFR § 164.504(e)(4), or if sharing such information falls under the definition of “business associate” in 45 CFR § 160.103:

(1) [B]usiness associate means, with respect to a covered entity, a person who:

(i) On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or

(ii) Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in § 164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.

(2) A covered entity may be a business associate of another covered entity.

(3) Business associate includes:

(i) A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information.

(ii) A person that offers a personal health record to one or more individuals on behalf of a covered entity.

(iii) A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.

Assuming one of the definitions above—“covered entity,” “organized health care arrangement,” or “business associate”—describes a CCO, the preemption question is whether the state law is contrary to the Privacy Rule and, if so, whether the state law is more stringent. “Health care operations,” as defined in ORS 192.556(4), include without limitation: “(a) Quality assessment, accreditation, auditing and improvement activities; (b) ***Case management and care coordination***; (c) Reviewing the competence, qualifications or performance of health care providers or health insurers; (d) Underwriting activities; (e) Arranging for legal services; (f) Business planning; (g) Customer services; (h) Resolving internal grievances; (i) Creating deidentified information; and (j) Fundraising.” Emphasis added. ORS 179.505(4)(b) permits disclosure for “scientific research, program evaluation, peer review, and fiscal audits,” but does not authorize disclosure of patient names unless necessary for the activity. IRS 179.506 permit sharing information among cooperating health care services providers for purposes of diagnosis or treatment. Separately or in combination, the state statutes defining “health care operations” do not appear as broad as the Privacy Rules’ definition of “health care operations,” in which case they are “saved” from preemption by their greater stringency.

* **Disclosure Permitted?** Assuming one of the definitions above—“covered entity,” “organized health care arrangement,” or “business associate”—applies to a CCO, then yes. There is no case law or rulemaking commentary concerning CCOs, so no authoritative answer is possible. A choice among these three HIPAA entities has implications that go beyond the scope of the present analysis.

**3. Recipient**:CCO Participant

**a. Purpose**:Treatment

* **Preemption**: HIPAA preempts state law if it is “contrary to” the Privacy Rule unless it is “saved” by an exception to the preemption provision. ORS 179.505(6) permits transfers of an individual’s records, when necessary or beneficial to the individual’s treatment, among providers of the Oregon Health Authority:

Nothing in this subsection prevents the transfer of written accounts referred to in subsection (2) of this ***section among health care services providers***, the Department of Corrections, the Oregon Health Authority or a local correctional facility when the transfer is necessary or beneficial to the treatment of an individual.

Emphasis added. A “health care service provider” means:

(A) Medical personnel or other staff employed by or under contract with a public provider to provide health care or maintain written accounts of health care provided to individuals; or

(B) Units, programs or services designated, operated or maintained by a public provider to provide health care or maintain written accounts of health care provided to individuals.

ORS 179.505(1)(b). ORS 192.561(1)(a) provides:

(1) ***Notwithstanding ORS 179.505,*** a health care provider that is a participant in a coordinated care organization, as defined in ORS 414.025, ***shall*** disclose protected health information . . . [t]o other health care providers participating in the coordinated care organization for treatment purposes . . .

Emphasis added. This is consistent with 45 CFR § 164.506(c)(2): A covered entity may disclose protected health information for treatment activities of a health care provider. The sharing of information also is mandatory, or “required by law.” 45 CFR § 164.512(a).

* **Disclosure Permitted?** Yes.

**b. Purpose**: Health Care Operations

* **Preemption**: HIPAA preempts state law if it is “contrary to” the Privacy Rule unless it is “saved” by an exception to the preemption provision. ORS 192.561(1)(a) provides, “[n]otwithstanding ORS 179.505,” that a health care provider “shall disclose protected health information” to the CCO for “health care operation purposes,” as permitted by ORS 192.558(2)(a). “Health care operations” are defined in ORS 192.556(4) to include without limitation: “(a) Quality assessment, accreditation, auditing and improvement activities; (b) Case management and care coordination; (c) Reviewing the competence, qualifications or performance of health care providers or health insurers; (d) Underwriting activities; (e) Arranging for legal services; (f) Business planning; (g) Customer services; (h) Resolving internal grievances; (i) Creating deidentified information; and (j) Fundraising.” The definition of “health care operations” in 45 CFR § 164.501 may be broader, but if so then the result would be that the state law is “more stringent” and therefore saved from preemption.
* **Disclosure Permitted?** Yes, to the extent of “health care operations” as defined in ORS 192.556(4).

**c. Purpose**:Payment

* **Preemption**: HIPAA preempts state law if it is “contrary to” the Privacy Rule unless it is “saved” by an exception to the preemption provision. Patient records may be disclosed without authorization to governmental agencies to secure compensation for services rendered in treatment of the patient. ORS 179.505(4)(c). This provision does not apply to private, third-party payers.

ORS 192.561(1)(a) provides, “[n]otwithstanding ORS 179.505,” that a health care provider “shall disclose protected health information” to a CCO for “payment purposes,” as permitted by ORS 192.558(1)(a). But the recipient of this disclosure is another CCO participant, presumably another health care provider, and not the CCO itself. This is consistent with 45 CFR § 164.506(c)(3), which permits a covered entity to disclose PHI to another covered entity or health care provider for payment activities.

* **Disclosure Permitted?** Yes.

**IV. Patient Written Authorization to Disclose**

**A. Part 2 Authorization**

In Section II, above, we describe the exceptions to the authorization requirement that are likely to come into play when sharing information between behavioral health providers. When an exception cannot be found, or is considered too “risky,” what are the requirements of a Part 2 authorization? They are set forth in 42 CFR § 2.31:

(a) *Required elements*. A written consent to a disclosure under these regulations must include:

(1) The specific name or general designation of the program or person permitted to make the disclosure.

(2) The name or title of the individual or the name of the organization to which disclosure is to be made.

(3) The name of the patient.

(4) The purpose of the disclosure.

(5) How much and what kind of information is to be disclosed.

(6) The signature of the patient and, when required for a patient who is a minor, the signature of a person authorized to give consent under § 2.14; or, when required for a patient who is incompetent or deceased, the signature of a person authorized to sign under § 2.15 in lieu of the patient.

(7) The date on which the consent is signed.

(8) A statement that the consent is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third party payer.

(9) The date, event, or condition upon which the consent will expire if not revoked before. This date, event, or condition must insure that the consent will last no longer than reasonably necessary to serve the purpose for which it is given.

A sample consent form is set out in 42 CFR § 2.31(b). The sample form in ORS 192.566 also was designed to meet the requirements of Part 2.

Note that the authorization requirements are somewhat flexible: they can expand or restrict the authorized disclosure. For example, the party disclosing Part 2 BHI can be a “specific name or ***general designation*** of the program or person.” Emphasis added. By contrast, on the receiving end, the authorization must designate “the name or title of the individual or the name of the organization to which disclosure is to be made.” The point is that the form requires greater specificity with respect to the recipient, as opposed to a “general designation” of the disclosing party or parties.

45 CFR § 2.32 provides that each patient authorization for disclosure must be accompanied by the following written statement reciting the prohibition against redisclosure:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

This authorization and documented disclosure permits the program to disclose Part 2 BHI in accordance with the terms of the patient’s written consent, except for disclosures to “central registries and in connection with criminal justice referrals.” Even with the patient’s written consent, these disclosures must meet the detailed requirements of §§ 2.34 and 2.35, respectively.

It should be noted that the program is not required to obtain the patient’s written consent when it discloses Part 2 BHI to the patient at the patient’s request. 42 CFR § 2.23(a). Even then, however, the patient is subject to the restrictions against use of the information for purposes of initiating a criminal investigation or criminal charges against the patient. 42 CFR § 2.23(b); *see* 42 CFR § 2.12(d)(1).

**B. Authorization to Disclose Other BHI**

A patient, or the patient’s personal representative, may authorize disclosure of records under ORS 179.505(3). Like the Part 2 written consent, the authorization under ORS 179.505(3) must be signed and dated by the patient and be revocable by the patient. ORS 179.505(3)(e). The patient may also specify a date or event upon which the authorization expires without express revocation. *Id*. The state authorization must contain:

(1) The name of the provider directed to make the disclosure (except when the recipients of or applicants for public assistance for certain purposes give the authorization);

(2) The name or title of the person or organization to which disclosure is to be made, or that the information may be made public;

(3) The patient’s name;

(4) The extent and nature of the information to be disclosed; and

(5) A “[s]tatement that the authorization is subject to revocation at any time except to the extent action has been taken in reliance” upon it, and a specification of the event, date, or condition on which the authorization will expire without express revocation.

ORS 179.505(3).

HIPAA’s authorization requirements are a bit more demanding: the authorization must describe the purpose of the disclosure, include statements concerning the conditioning of care or coverage upon the granting of authorization, and the potential for redisclosure. To this extent, the authorization in ORS 179.505(3) is displaced by HIPAA.

When the authorization concerns psychotherapy notes, a specific and separate authorization is required. ORS 179.505(17)(a). 45 CFR § 164.508(a)(2) requires an authorization for any use or disclosure of psychotherapy notes. With respect to the “use” of psychotherapy notes, the state law and the federal Privacy Rule require authorization for use except to carry out treatment or for other limited purposes. Again, the form set out in ORS 192.566 was designed to meet the requirements of ORS 179.505, although separate authorization would be required for some uses or any disclosure of psychotherapy notes.

1. 45 CFR § 164.502(g)(2); *see* OCR’s “Summary of the HIPAA Privacy Rule – Other Provisions: Personal Representatives and Minors,” and “For Covered Entities and Business Associates – Personal Representatives.” [↑](#footnote-ref-1)
2. We do not discuss the exceptions contained in 42 CFR §§ 2.12(c)(5), (crimes on premises), or 2.52 (research), or 2.61 to 2.67 (court orders), as they are not suited to sharing Part 2 BHI for coordination of care, payment, or administrative purposes. [↑](#footnote-ref-2)
3. The exception to the redisclosure prohibition is the subject individual or that individual’s personal representative. [↑](#footnote-ref-3)