DASPOP
Organized For Advocacy

Drug & Alcohol Service Providers Organization of Pennsylvania

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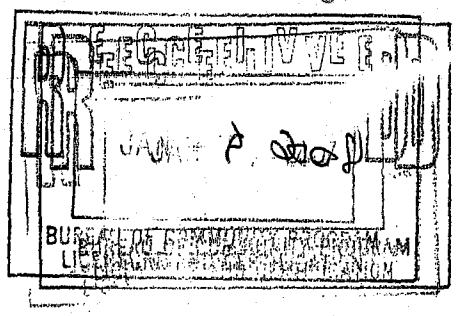

Janice Staloski, Director
Bureau of Community Program Licensure
and Certification
Department of Health
132 Kline Plaza, Suite A
Harrisburg, PA 17104

Dear Janice Staloski,

Thank you for giving us the opportunity to review and comment on the Department of Health's Proposed Regulation No. 10-186 regarding confidentiality of drug and alcohol addiction treatment patient records and information.

Through this regulation, the state is proposing to dramatically loosen the confidentiality protections of 4 PA Code §255.5(b) which currently, stalwartly protect the privacy of thousands of patients and families seeking help for addiction to alcohol and other drugs.

On behalf of the Drug and Alcohol Service Providers Organization of Pennsylvania (DASPOP), I am writing to express our strenuous objections to these proposed changes.

Our objections are based on the need for strong privacy protections regarding this often fatal illness, the substitution of ambiguous and complicated federal and state standards on what information is permissible to release, potential conflict and undermining of Pennsylvania's Act 106 of 1989, the history of incompetently handled records by insurers, the failure of the Department of Health to properly consult its Advisory Council on Drug and Alcohol Abuse and effected parties and the creation of an expensive administrative burden.

The Critical Role of the Existing Federal and State Confidentiality Protections

The Federal confidentiality regulations (42 CFR, Chapter 1) and our state's iteration of them in PA 4 Code have long played critical roles in ensuring that people with untreated alcohol and other drug addictions are able to seek treatment for this often fatal illness that effects 1 in every 4 of our families.

The existing federal and state rules on this issue are quite learned and reflect both strong knowledge about untreated alcohol and drug addiction and an unusually astute understanding of the nature of the stigma that continues to surround the illness.

Contrary to #8 of the Regulatory Review Analysis, there is no "conflict" between 4 PA Code §255.5(b) and the federal confidentiality regulations. 4 PA Code §255.5(b) merely clarifies what information can be released with and without consent of the patient.

The existing federal and state confidentiality rules work efficiently together to minimize several major reasons why addicted individuals stay out of treatment while simultaneously, enhancing the public interest and protecting public safety. Those major reasons for staying out of treatment are of course, stigma, embarrassment and fear of consequences regarding employment, health and life insurance and other matters.

Families and the addicted person alike are embarrassed and ashamed and see untreated addiction as evidence of severe failing as parents, spouses and of weakness in the individual. Even with the existing privacy protections, many people with addictions stay out of treatment for years after the problem has become evident to doctors, family members, co-workers and neighbors. There is research on this point.

The Substance Abuse and Mental Health Services Administration, 2001 National Household Survey on Drug Abuse identified nine reasons why people with untreated drug and alcohol problems stay out of treatment. Three of the nine factors chosen by 48% of the responders involve stigma and embarrassment.

At the same time that stigma keeps people out of treatment, research has conclusively demonstrated that people with untreated addictions increase the cost of health care for drug and alcohol related accidents and illnesses, increase costs in the workplace through accidents, absenteeism and disciplinary problems and create mayhem in families resulting in use of other health and human services by the family. In addition, some people with addictions deteriorate into the criminal justice system with all of the attendant costs of crime, harm to victims, prosecution and incarceration.

For all of the reasons listed above, financial and humanitarian, it is in the interest of the state to maintain strong confidentiality rules to minimize embarrassment and fear of exposure and to remove any hesitation to get help.

In summary, the current federal and state confidentiality rules recognize that it is in the interest of the individual, the family and the broader society when people with untreated addictions enter treatment. In fact, the costs to society of untreated addiction are horrific both in terms of the destruction of human lives and billions spent annually on addiction related illnesses and fatalities, emergency care and crime.

We must tread carefully here, for much is at stake.

What Will the Proposed Changes to the State Protections Do?

1) Expose Sensitive, Private Information and Create Administrative Burdens

The proposal before us will gut 4 PA Code §255.5(b) which currently limits disclosures and protects patient and family privacy and will greatly increase personal information shared with insurers and third-party payers. These changes will force treatment programs to rely on what is essentially the language of the Federal Regulations 42 CFR Ch. 1.

This is an alarming proposal as the federal rules on confidentiality by themselves provide little protection of sensitive patient records and embarrassing personal information about the patient and family.

Federal 42 CFR Ch. 1, §2.13 Confidentiality Restrictions., reads in part:

> *"Any disclosure made under these regulations must be limited to that information which is necessary to carry out the purpose of the disclosure."* (Emphasis added)

The proposed regulation, (c)(2)(i), reads in part:

> "A program shall limit the patient information released to government officials and third-party payers to the information necessary to accomplish the specific purpose for the disclosure." (Emphasis added)

The Federal rule and now, this state proposal – without the helpful guidance of the existing 4 PA Code §255.5(b) will force treatment programs and patients alike to wrestle with the appropriateness of the release of each data element to ensure that it is really necessary to the purpose of the disclosure. It will create a purposeless administrative and potentially, a legal burden.

Under the federal confidentiality rules alone and now under this new proposal, it is not clear what kind of information could ever be withheld from payers – even where that information is personally embarrassing, detrimental and of utterly no relevance to the treatment of the addiction. Yet, our guilt-filled population is quite vulnerable when entering treatment and likely to give consent and sign away almost any right mediated through a helper.

In addition, section (c)(2)(i) of the new rules dramatically expands the information that can be released – and that the programs are sure to be pressured to release – to government officials and third-party payers making medical necessity admission determinations, continued stay reviews, etc.

The proposed new section (c)(2)(ii)(A)-(G) requires a lengthy inventory of mostly new information to be provided to the insurer. Almost all of the items listed have been used by unfairly by third-party payers to deny treatment. Some of these items have been used to downcode the level of treatment provided when they are in fact, indicators of a need for more intensive care. (For example, wavering motivation) In the past, even desperately ill patients have been penalized for not being mentally ill or on the other hand, have been penalized for having a stable home(!) – and therefore, denied treatment.

Many of the items are also quite variable in nature. For example, levels of detoxification fluctuate constantly, there is the matter of primary and secondary withdrawal from a multitude of different drugs, information on the drugs used is generally not reliable and social supports and stressors, relapse triggers and motivation also vary widely over time. This information should not be made available for use by third-party payers who are not treating the patient and are not liable for the care.

In summary, the proposed changes will create new administrative and potentially legal burdens while needlessly exposing vulnerable patients.

2) Endanger the Patient/Counselor Relationship and Effective Treatment

Under the existing 4 PA Code §255.5(b), what information can currently be released to insurers and payers with the consent of the patient?

4 PA Code §255.5(b) limits disclosure to:

--- Whether the client is or is not in treatment
--- The prognosis of the client
--- The nature of the project
--- A brief description of the progress of the client
--- A short statement as to whether the client has relapsed into drug, or alcohol abuse and the frequency of such relapse

The proposal before us to change 4 PA Code §255.5(b) raises many concerns by allowing disclosure of information well beyond the particulars of the addiction.

First and foremost, we are concerned about the sensitivity of the material and the danger to the patient/counselor relationship. Without a relationship securely anchored in trust and undergirded by the rule of state regulation, effective treatment is unlikely to occur.

In direct contradiction to broader societal goals as well, such a change will create a negative incentive to stop drug use through seeking help. Please note that our facilities are mandatory child abuse reporters and we already report serious crimes and work with our patients beyond this to ensure that they make amends publicly and privately for other actions. However, it is important to know that most of the secrets blocking entry to treatment are deeply personal embarrassments of a non-criminal nature.

Drug and alcohol addiction treatment facilities are required under licensure by the Department of Health to obtain detailed psycho-social histories. During these interviews, we learn about family relationships, delve into difficult experiences and explore many issues that are sensitive and embarrassing to our patients and their families – and frankly, would be for the rest of us as well.

Do we really want to share such information with a payer for the treatment of a disease?

We think the information shared now is properly limited to material about the addiction itself and that the state rules (4 PA Code §255.5(b)) simply clarify the federal regulations.

What is it that the payers could possibly need beyond this?

3) Potentially Undermine Pennsylvania's Act 106 of 1989

The proposed changes to the state confidentiality rules could be used by third-party payers in their ongoing efforts to bypass Act 106 of 1989 through the use of medical necessity reviews.

This very issue is currently before the Supreme Court of Pennsylvania.

Here's the concern. These changes appear to permit the insurer and health plans to do medical necessity reviews and pre-certification of admissions. In addition, the changes appear to allow the insurer to collect information far beyond the express provisions of Act 106 and discussion of the addiction. What is the purpose for allowing this violation of privacy?

This proposed language would substantially expand the information permitted to be disclosed to health insurance companies. The new language would essentially permit a facility to disclose, to insurers and managed care companies, a detailed narrative covering virtually every aspect of the client's history, condition, and treatment. (See proposed sections (c)(2)(i) and (ii)). Experience teaches us that managed care companies will require facilities to disclose all the information that the facility is permitted to disclose – in other words, while the new language is framed as a limitation, it will, if adopted, come to be used or argued by insurers to define what facilities must disclose to managed care companies, as a condition of reimbursement.

For a patient entitled to the protections of Act 106 of 1989, this broad disclosure clearly frustrates the intent of that statute, which is to permit patients to receive treatment <u>without managed care interference</u>. It is clear from long experience that managed care companies will take the position that they cannot tell whether or not a patient is subject to Act 106, and will therefore insist that they are entitled to the full litany of information required under proposed sections (c)(2)(i) and (ii) for every patient. While it is not difficult to envision regulatory approaches that require managed care companies to distinguish between Act 106 patients and non-Act 106 patients, there is nothing in the current or proposed

regulations that requires them to do so. Thus, in practical effect this regulation will require and empower the techniques, processes and burdens of managed care medical necessity review, even for Act 106 patients.

It should also be noted that managed care interference imposes significant burdens on facilities, which are already overtaxed by managed care information requests and which struggle to meet managed care demands for patient information even under the current regulations. It would require significant resources for facilities to gather and prepare the information required/permitted to be disclosed under proposed sections (c)(2)(i) and (ii). This will make it even more difficult and burdensome for facilities to treat managed care patients.

Background on Act 106 of 1989 and the Courts

Act 106 of 1989 requires all commercial group health plans in Pennsylvania to provide treatment for alcohol and drug addictions and includes language specifying who is permitted to certify and refer to treatment.

This issue was further addressed by the PA Insurance Department rule, Notice 2003-06.

According to the 8/8/03, PA Insurance Department rule, *Notice 2003-06, "Drug and Alcohol Use and Dependency Coverage"*,

> ". . . the only lawful prerequisite before an insured obtains nonhospital residential and outpatient coverage for alcohol and drug dependency treatment is a certification and referral from a licensed physician or licensed psychologist." (Emphasis added)

The Notice also states:

> "The certification and referral in all instances controls both the nature and duration of treatment."

In January of 2004, the insurers challenged the Insurance Department's Notice 2003-06 in Commonwealth Court. The Insurance Department and the Office of the Attorney General joined together to argue the case before the Court. In addition, the Pennsylvania District Attorneys Association filed an Amicus brief and a separate Amicus brief was also filed by the County Commissioners

Association of Pennsylvania, the Pennsylvania Association of Drug and Alcohol Administrators, the Pennsylvania Children and Youth Administrators, the Pennsylvania Council of Chief Juvenile Probation Officers and the Pennsylvania Association of Student Assistance Professionals.

On 7/26/07, the PA Commonwealth Court upheld the Insurance Department by a 7-0 ruling stating in part:

> *"Based on its analysis of the issues and the law, the Court concludes that the Department's position in this matter is correct, and it therefore declares that Act 106 requires group health insurers to provide mandatory coverage for alcohol and drug abuse treatment once an insured receives a certification and a referral for treatment from a licensed physician and/or a licensed psychologist. Accordingly, the Court holds that the Department is entitled to judgment on the pleadings as a matter of law." (Emphasis added)*

On 10/29/07, the insurers appealed the July ruling of the Commonwealth Court to the Pennsylvania Supreme Court. Briefs from all parties have been filed shortly.

In summary, the Commonwealth of Pennsylvania is speaking with one voice on this issue. This voice includes: the Office of the Attorney General, the Insurance Department, the Pennsylvania District Attorneys Association, the County Commissioners Association of Pennsylvania, the Pennsylvania Association of Drug and Alcohol Administrators, the Pennsylvania Children and Youth Administrators, the Pennsylvania Council of Chief Juvenile Probation Officers and the Pennsylvania Association of Student Assistance Professionals. All are united in pressing for enforcement of Act 106 and the plain meaning of the statute.

For those wishing to cast a cloud of confusion over the release of data, these new rules may provide that opportunity. They are sure to be used by health plans to argue for personal information far beyond the express provisions of Act 106 and the discussion of addiction.

What is the purpose of allowing these violations of privacy?

4) Potentially Undermine the Pennsylvania Client Placement Criteria

During enactment of Pennsylvania's welfare reform, the Department of Public Welfare committed to use the Pennsylvania Client Placement Criteria as the definition of medical necessity for purposes of treating people with addictions under HealthChoices/Medicaid.

This new, proposed regulation would require a change in procedures and contracts. Most importantly, this new, proposed regulation also changes the commitment of the Department of Public Welfare during welfare reform to the Placement Criteria.

We are deeply troubled by this proposal and wonder why the state would want to allow payers to delve into the personal information of the most vulnerable patients in this state in this way.

5) Increase the Vulnerability of Patients When Records are Lost

We are also concerned about the ability of the state to enforce any confidentiality protections in regard to payers.

The track record of third-party payers with privacy and confidentiality of records is less than stellar.

Already under the current rules, documents properly released to payers are frequently lost. Treatment facilities across the state document that insurers and managed care companies repeatedly ask for and lose the same information over and over again – even where it is sent via certified mail. Under these new rules, still more sensitive and personal information will be forced into circulation and subject to such carelessness.

The state itself is also struggling with privacy violations with existing state databases. In September of 2007, computers were stolen from the Department of Public Welfare containing personal information of approximately 375,000 people who receive treatment for mental health and drug and alcohol problems through Medical Assistance. (Philadelphia Inquirer, 9/12/07) In November of 2007, a computer containing personal information was stolen from one of the Department of Public Welfare's county assistance office. (Harrisburg Patriot News, 12/8/07)

Other state agencies are experiencing similar thefts of personal information. As reported in the Harrisburg Patriot News, a computer containing personal

information on nearly 21,000 senior citizens was stolen from a home of an employee of the Department of Aging and the Department of Transportation discovered the theft of hundreds of cards and laminate overlays used to produce licenses and ID cards putting Pennsylvanians at risk of fraud and identity theft. (Harrisburg Patriot News, 12/19/07)

Yes – certainly this is the computer age and new technology continues to be developed to safeguard privacy. But given that the sophistication of hackers seems to exceed the ability of government to protect privacy, we must ensure that only minimal information is available in these databases.

6) Increase Coercion by Third-Party Payers to Release Information

Currently, insurers and other third party payers try to coerce release of documents beyond those permitted by 4 PA Code §255.5(b) by threatening to withhold payment to programs and patients or threatening to refuse to do business with treatment programs that, are in fact, complying with state rules.

Let me re-state this point. Currently, treatment programs that comply with the state requirements are sometimes penalized by third party payers with payments held hostage to coerce breaking of the rules.

Over the years, despite repeated efforts by our association and others, the state has failed to crack down on these coercive actions by payers. Why would the state now reward this coercive activity?

Worse, the ambiguity of the new proposed section (c)(2)(i) is a virtual invitation to additional coercion of this sort. How do we set limits and know what can be maintained in a private fashion when the rules read *"A program shall limit the patient information released . . . to the information necessary to accomplish the specific purpose for the disclosure."*? Surely, insurers and third-party payers will always challenge the sufficiency of the response and will always ask for ever more intrusive data.

In addition, proposed section (c)(2)(ii)(A)-(G) is also quite ambiguous and open to interpretation whereas the original state rules are blessedly clear. (Please see the concerns raised under "Exposure Sensitive, Private Information and Create Administrative Burdens", page 3)

Failure to Allow Proper Review of the Proposed Regulation by the PA Advisory Council on Drug and Alcohol Abuse and Effected Parties

Act 63 of 1972, the Pennsylvania Drug and Alcohol Abuse Control Act, established the Pennsylvania Advisory Council on Drug and Alcohol Abuse and imposed duties on the Department of Health to develop and coordinate a plan for the prevention and treatment of alcohol and drug abuse and addiction.

Under the statute, Section 3,(e)(2):

> "The Department of Health shall seek the written advice and consultation of the council in the following areas:
>
> . . .
>
> The promulgation by the Department of Health of any regulations necessary to carry out the purpose of this act." (Act 63 of 1972) (Emphasis added)

Without prior consultation or written advice from the Council, in January of 2007, proposed regulations to change the state confidentiality rules were prepared for publication in the Pennsylvania Bulletin by the Department of Health. At the 1/25/07 meeting of the Advisory Council on Drug and Alcohol Abuse, the Council learned about this from a member of the audience – not through any official notification or request for written advice from the Department.

The Council voted immediately to oppose any changes to the state rules and directed the Advisory Council to send a letter stating this opposition to the Secretary of Health, the Governor, the House Health and Human Services Committee, the Senate Public Health and Welfare Committee and the Independent Regulatory Review Commission.

After this vote by the Council and during the meeting, the Department then committed to share the regulations with the Council and effected parties before they would be sent to the Pennsylvania Bulletin.

On 2/26/07, the Council, treatment programs, recovery groups and others received the draft for review and a number of letters were sent to the Department expressing strong opposition.

At the 4/11/07 meeting of the Advisory Council, Council members discovered that despite their vote and clear direction, their letter of opposition had not been sent to the Committees of jurisdiction, the Secretary of Health, the Governor and the Independent Regulatory Review Commission. Once again, they voted to oppose any changes to the state rules on confidentiality and directed that a letter be sent out on their behalf – this time – within 72 hours.

> "I motion that the Secretary of Health send a a letter (*in 72 hours*) to the Governor, Department of Health, the House Health and Human Services Committee, the Senate Public Health and Welfare Committee and the Independent Regulatory Review Commission, stating opposition to any changes to the confidentiality regulations of the Commonwealth." (PA Advisory Council on Drug and Alcohol Abuse, Minutes - 4/11/07)

We are unsure but do not think that a letter reflecting this second vote of opposition to any changes in the state rules by the Council was sent to the Pennsylvania State Legislature and other intended parties.

In the interim, two Council meetings were cancelled. At the October meeting, draft regulations may have been provided with a stack of other material as the members were seated at the table – i.e. – no advance time for review. Some present at the meeting don't remember the subject coming up at all. Others think it did but in a perfunctory fashion. In any case, there was no request for written advice from the Council.

At the end of November, the Department forwarded new regulations to the committees of jurisdiction and shortly thereafter to the Pennsylvania Bulletin for publication. Once again, neither the Council nor field groups were afforded the opportunity to review this new and quite different proposal before its entry into the regulatory process.

In summary, the proposed rules will weaken, confuse and complicate the issue of confidentiality protections of sensitive patient information.

Frankly, we are puzzled and concerned. Although the narrative and regulation are lengthy and quite detailed, in the main they reiterate requirements already in place in state or federal rules. The major changes here appear to be limited to assisting insurers and the government in getting ever more personal and sensitive information.

For all of the reasons delineated, we strenuously object to the Department of Health's Proposed Regulation No. 10-186.

Sincerely,

Deb Beck, MSW
President/DASPOP

Please see the attached:

Section-by-Section Review of the Proposed Amendments
Comments on the Regulatory Analysis Form

DASPOP is a statewide coalition of drug and alcohol abuse prevention, education and addiction treatment programs, practitioners, employee assistance programs, county and statewide drug and alcohol associations, student assistance professionals, prevention specialists, counselors and other addiction professionals. Our membership includes the full continuum of services, including prevention, education, intervention, DUI programs, hospital and non-hospital detoxification and rehabilitation, outpatient, partial hospitalization, halfway houses, transitional living facilities, prison treatment and dual-diagnosis programs.

Section- by-Section
Review of the Proposed Amendments to 4 PA Code §255.5(b)

(a) Definitions.

Patient information – This term is defined as identical to "Patient record". These are not the same.

Medical authorities and medical personnel – This definition is quite broad and includes persons not normally included in such a definition. The definition of the term is highly misleading and sure to become a matter of debate.

(c)(1) – Consensual Release of Patient Records and Information.

Under this language, the entire patient record not just the medical record is being released. This is improper. Also, given the overly broad definition of medical personnel in the definition section, it is not clear who would be receiving this information. This section could be used in combination with the ambiguous definition of medical authorities to bypass the requirements of proposed section (2) that follows.

(c)(2)(i) – Consensual Release of Patient Records and Information.

In this section, third-party payers will be able to receive information "necessary to accomplish the specific purpose for the disclosure". This amendment is wide open and ambiguous and would allow the insurer to request information far beyond the illness and what is needed for the purpose of diagnosis, referral and medical necessity review.

(c)(2)(ii) – Consensual Release of Patient Records and Information.

Although this section appears to limit the type of disclosure permissible to be given to third party payers, in reality it expands information that can be requested far beyond the illness and what is needed for the purpose of diagnosis, referral and medical necessity review.

Further, in regard to commercial group health insurance plans, Act 106 of 1989 already defines what is necessary to access addiction treatment for group

health plans falling under its requirements. Under Act 106, to access addiction treatment, "the only lawful prerequisite . . . is a certification and referral from a licensed physician or licensed psychologist." (See "Potentially Undermine Pennsylvania's Act 106 of 1989", pages 6, 7 and 8)

During enactment of Pennsylvania's welfare reform, the Department of Public Welfare committed to use the Pennsylvania Client Placement Criteria as the definition of medical necessity for purposes of treating people with addictions under HealthChoices/Medicaid.

This new, proposed regulation would require a change in procedures and contracts. Most importantly, this new, proposed regulation also changes the commitment of the Department of Public Welfare to the Placement Criteria during welfare reform.

We are deeply troubled by this proposal and wonder why the state would want to allow payers to delve into the personal information of the most vulnerable patients in this state.

(f)(1)(viii) – Consent Form.

The consent form has one new element that is different from prior rules. This is (f)(1)(viii) which provides for an oral consent to allow information to be released. Some patients under the influence of drugs and alcohol will be "physically unable to provide a signature" and this section could be utilized to obtain consent. We are concerned about this.

Comments on the Regulatory Analysis Form

8. There is no "conflict" between the existing state and federal confidentiality rules. The existing 4 PA Code §255.5(b) merely provides simple and uncomplicated guidance on what information may be provided, to whom and under what circumstances. The proposed rules on the other hand, are extremely complex and ambiguous in nature and they are sure to create a new battleground over data that will result in delays and denials of access to treatment.

10. There are no federal or state laws or regulations or court orders calling for any change in the state rules.

11. There is no compelling public interest that justifies this new proposed regulation. There is no "conflict" between the state and federal rules, nor are the existing rules "outdated", nor do they "impede service delivery and coordination of care."

    In fact, treatment programs currently coordinate treatment for medical and other conditions for patients under their care without any impediment by the existing rules.

    The proposed new rules are ambiguous and will create a battleground over information that is sure to become an obstacle and a new excuse to deny or delay treatment.

12. There are no risks here to public health, safety, environmental or general welfare if the state were to make no changes at all.

13. There is no benefit here to patients or programs or access to treatment or coordination. Quite the opposite. New, sensitive data will be placed at risk (see "Expose Sensitive, Private Information and Create Administrative Burdens, pages 3 and 4) and third-party payers will insist upon obtaining ever more intrusive personal information – much of it inappropriate to considerations of medical necessity. This data will be added to the list of reasons currently employed to deny treatment.

    Licensed treatment programs are already able to coordinate care under the current rules.

14. While the Department is correct that state and federal rules will still be in place, this proposed regulation will open the door to the release of a flood more sensitive and personal information.

Already, some families with addicted loved ones, self-pay for treatment to avoid creation of a record – others delay treatment because of this concern.

The fourth paragraph of #14 of the Regulatory Review Analysis Form simply reiterates all the data elements that already must be included in a standard release of information form including: specific information to be disclosed, the specific purpose of the disclosure, the name of specific individual or entity receiving the information, a specified time limit, the signature of the patient, witnesses and the date.

Why is a new rule required?

16. Please see "Failure to Allow Proper Review of the Proposed Regulation by the PA Advisory Council on Drug and Alcohol Abuse and Effected Parties", pages 11 and 12. Please note that the Pennsylvania Advisory Council on Drug and Alcohol Abuse has already voted twice to oppose any changes to the state rules.

17. Implementation of these new regulations will be confusing and will require a great deal of training time for the 600+ prevention and treatment programs and staff across the Commonwealth.

25. Pennsylvania's existing regulation - 4 PA Code §255.5(b) - has often received praise nationally for its clarity and protection of privacy. Why would we change it?

26. The proposed regulations are likely to conflict with actions by the Insurance Department, the Attorney General's Office and the Commonwealth Court ruling regarding Act 106 of 1989. (See "Potentially Undermine Pennsylvania's Act 106 of 1989", pages 6, 7 and 8) and the agreements made by the Department of Public Welfare delineated in "Potentially Undermine the Pennsylvania Client Placement Criteria", page 9.

28. Yes, see number 26 above and be sure to see "Potentially Undermine Pennsylvania's Act 106 of 1989" on pages 6, 7 and 8 which discusses all the new reporting and other burdens that will be created.

Philadelphia Inquirer
9-12-07

State Welfare Dept. computers stolen

HARRISBURG — Burglars stole two computers containing information, including Social Security numbers, on people who receive medical assistance benefits for treatment of mental health and substance-abuse problems, Pennsylvania state officials said yesterday.

The Department of Public Welfare has begun notifying about 375,000 people who receive behavioral health services and could potentially be affected, Welfare Secretary Estelle Richman said in a statement. The department is telling the consumers what they can do to avoid identify theft.

The information on the stolen computers was protected by multiple passwords, and most of it was coded and did not identify anyone by name, Richman said. Information for more than 1,800 consumers, however, included names and Social Security numbers. Officials discovered the burglary on Aug. 22 at a department office building. — *AP*

Patriot News
Dec. 8, 2007

Welfare agency loses data to thieves

Department took weeks to tell clients

BY JAN MURPHY
Of The Patriot-News

Welfare Secretary Estelle Richman, left, will be questioned about the thefts of computers containing personal information about welfare records that were stolen from a state Department of Public Welfare office.

For the second time in three months, a computer containing welfare records was stolen from a state Department of Public Welfare office.

The latest theft occurred during a Nov. 13 burglary at a county assistance office in Philadelphia. The stolen computer contains information about 86 welfare clients, all from Philadelphia, department spokeswoman Anne Bale said.

As of Friday, she said, there had been no indication of misuse of the password-protected information that included the names and Social Security numbers of 14 clients and the names and addresses of 72 clients, Bale said.

A notification about the early morning burglary went out on Wednesday to the affected clients, she said. The burglary was discovered by police who were alerted to the locked office by an alarm that sounded, she said.

This incident follows an Aug. 22 burglary that occurred at the department's Office of Mental Health and Substance Abuse Services in Susquehanna Twp. During that incident, two computers were stolen that contained medical histories of about 375,000 Pennsylvanians, and the names and Social Security numbers of 1,819 of them.

In both instances, about three weeks passed between the time the burglary occurred and when notifications went out to the potential victims.

"Certainly, the three-week span was not the ideal, but we did want to make sure everything was correct before we made an announcement," Bale said. "Hopefully, this never happens again. Hopefully, we'll be more prepared the next time."

Erik Arneson, a spokesman for Senate Majority Leader Dominic Pileggi, R-Delaware, noted a 2005 state law requires that notice of a breach like this occur "without" an unreasonable delay."

Welfare Secretary Estelle Richman "owes the public a detailed and thorough explanation of why they were unable to prevent the second theft, and why in both cases it took so long to notify the people whose personal information was stolen," Arneson said.

He said Richman will be questioned about the incidents at the department's spring budget hearing, if not a separate hearing.

The news of a second incident of a potential security breach of welfare clients' confidential records disturbed Deb Beck, president of the Drug and Alcohol Service Providers Organization of Pennsylvania.

"These break-ins emphasize the importance of severely limiting information in confidential records," she said.

She fears that "stigmatized populations" might eventually be "afraid to go for help."

The department will provide credit protection for the next year to the 86 individuals whose information was contained on the computer taken from the Philadelphia office, Bale said.

It is providing similar protection to the thousands of welfare clients affected by the August computer at a cost, as of October, that totaled $36,739.

Bale said the department has received no indication that information about those clients has been used inappropriately.

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Stolen laptop holds data on seniors

BY JAN MURPHY 12/19/07
Of The Patriot-News

A state Department of Aging-owned laptop computer containing personal information on nearly 21,000 senior citizens was stolen from a Johnstown home during a Dec. 5 break-in.

The computer was issued to a department employee who works with the agencies on aging in Indiana, Union, Snyder and Clearfield counties.

The employee was attending a funeral when the theft occurred, said Michele Bell Gopinath, a department spokeswoman. Police suspect the computer was taken for its street value, she said.

There have been no reports of misuse of the information, which included names, addresses, Social Security numbers, some medical information and the services clients received, Gopinath said.

The affected seniors are in the process of being notified, and credit protection from TransUnion will be provided for 90 days at a cost to the state of $23,000, she said. Seniors then have the option of having the credit protection extended for a year at the state's expense.

Information on the computer was double password protected, Gopinath said.

CONSUMER ALERT

Concerned residents can call this toll-free line: 866-592-8622

When the theft occurred, she said the department was in the process of encrypting computers and has since completed that work to provide additional protection. It also is in the process of centralizing information about clients so that the information does not have to be downloaded onto laptops when employees are out in the field, but that work is not completed, she said.

"We believe this was an isolated incident and that the provisions we've taken with contacting TransUnion and contacting the consumers, should give our consumers and clients a sense of safety," Gopinath said.

This is the third incident in four months where state-owned computers containing personal information of Pennsylvanians have been stolen. The other two thefts involved computers that contained information on more than 375,000 welfare clients.

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Thefts spur PennDOT security measures

BY MARK SCOLFORO 12/19/07
Of The Associated Press

Lax security enabled the theft of materials used to produce Pennsylvania driver's licenses and identification cards, putting people at risk of fraud and identity theft, the state auditor general said Tuesday.

Contractors hired since 2000 to produce licenses and ID cards for the Pennsylvania Department of Transportation were not properly monitored and trained, Auditor General Jack Wagner said. As a result, hundreds of cards and laminate overlays were stolen or unaccounted for, he said.

Wagner said PennDOT has taken effective steps to address the problem.

"In all frankness, we have a far greater comfort level now, in 2007, than going back several years ago," he said.

From 2003 to 2005, 1,500 blank cards and a roll of 100 holographic overlays were reported stolen, the auditor's report said. In addition, it said, there was evidence that a sleeve of 500 blank cards may have fallen through the accounting cracks and there was no record of whether multiple shipments of voided cards had been destroyed.

"We do take that security of our products and the security of customer information very seriously," PennDOT spokeswoman Danielle Klinger said. "These weaknesses ... were identified and we took certain corrective action to minimize the risk."

Klinger said there has been no evidence that the stolen or missing material has been used to make bogus licenses or identification.

Wagner said he was satisfied that changes PennDOT has made to fix the problem are sufficient.

"When they respond to us in writing and say that those measures are in place, that is verification to us, as auditors, that they have taken corrective action," Wagner said.

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THE PENNSYLVANIA ADVISORY COUNCIL ON DRUG AND ALCOHOL ABUSE

DATE: January 25, 2007

MEETING MINUTES

In Attendance

Dr. Calvin B. Johnson, Secretary of Health; Gene R. Boyle, Director, Bureau of Drug and Alcohol Programs (BDAP); and BDAP staff Maureen A. Cleaver; Jackie Spaid; Robin L. Rothermel; Hector L. Gonzalez; Ronald A. Kauffman; and Janet Musser.

Members Present

George W. Dowdall, Ph.D.; Trusandra Taylor, M.D.; Peter Wambach; A. Thomas McLellan, Ph.D.; Carlos E. Graupera; and Marlene Burks.

Absent

Guy Diamond, Ph.D. and Kenneth S. Ramsey, Ph.D.

Guests in Attendance

Arvida Wanner, Division of Drug and Alcohol Program Licensure (DAPL); Deborah Graeff, DAPL; Andrea Robertson, Reckitt Benckiser; Terri Wray, Pennsylvania Certification Board (PCB); Mark Sarneso, CRC and Drug and Alcohol Service Providers of Pennsylvania (DASPOP); Deb Beck, DASPOP; Beth Pickering, Community Care Behavioral Health; Charles Morgan, M.D., Parkside/NHS Human Services; Berenth Irwin, New Directions in Frankford; Randolph Clark, Parkside Recovery Center; Cheryl Floyd, Pennsylvania Recovery Organizations Alliance (PRO-A); Michael Flaherty, Ph.D., Institute On Research, Education and Training in Addictions (IRETA); Sue Duff, BDAP; Dan Klarsch, BDAP; and Robert Rounce, BDAP.

Welcome and Introductions

Secretary Johnson welcomed the Council members and guests to the meeting and introductions were provided.

Mr. Boyle asked that the October 25, 2006 minutes be accepted by the Council. There was a motion made and seconded to accept the minutes.

Buprenorphine

Mr. Boyle informed Council that Buprenorphine would be the topic of discussion for today's meeting.

Mr. Boyle provided Council with background information on Buprenorphine:

- *Buprenorphine was approved by the FDA in October, 2002 for office-based treatment of opioid dependence*
- *There is a federal regulation that any physician must have at least eight hours of approved training and pass a certification exam.*
- *There is a 30 patient limit per physician who has been prescribing Buprenorphine for less than a year. For physicians who have been prescribing for more than a year, the patient limit is 100.*
- *Department of Health (DOH) regulations, regarding the use of narcotics for the treatment of opiate dependence, apply only to licensed facilities – not physicians in private practice.*

Mr. Boyle reminded Council that at the October 25, 2006 meeting there was consensus among Council members that the DOH regulations have many restrictions that prevented the field from providing services. Mr. Boyle then requested that Dr. McLellan address these concerns and present an overview.

Dr. McLellan discussed various research that has been conducted regarding Buprenorphine and other medications available to treat substance abuse. Some of the major points made are as follows:

- *Drug-free detoxification for opiate users does not work well; its effectiveness is measured in hours, not in days.*
- *Residential treatment is effective, but it is expensive and there is limited capacity.*
- *The Internet has become one of the easiest ways to obtain narcotics. These drugs (Oxycotin, Vicadin, etc.) can be delivered to your door.*

- *Outpatient drug-free treatment, by itself, does not have a good track record with opiate addiction. It is very difficult to retain patients for long periods of time.*

- *Naltrexone is an adjunct treatment that is successful, but patients stop taking the medication.*

- *Outside of Methadone clinics, Methadone cannot be prescribed for more than 3 days. Anything after 3 days must be prescribed in a methadone maintenance program. It is one of the most successful treatments of opiate dependence, and one that has been thoroughly researched.*

- *Methadone programs were also established to restrict the diversion potential and to add community support and counseling services in one package.*

- *The advantages of Buprenorphine and why it should be more available throughout the Commonwealth.*

    1. *It is orally administered with an effectiveness of 24-36 hours.*

    2. *Buprenorphine has a safer profile and virtually no overdose danger.*

    3. *It is the only medication of its type that can be prescribed in trained physicians' offices.*

    4. *It is not a replacement for Methadone.*

Dr. McLellan talked about what is done to protect the patients.

- *Doctor's must be qualified and certified before prescribing Burprenorphine.*

- *There are restrictions on the number of patients a physician can treat.*

- *The medication should be prescribed in addition to clinical services and counseling.*

Dr. McLellan stressed that there are alternatives such as Buprenorphine. We need to have a system which will allow for medicated assisted treatment and have a setting

able to provide such medication. This treatment option could open doors for primary care physicians in Pennsylvania.

Secretary Johnson opened the floor for Council discussion.

Dr. Taylor asked if there were state data that would show the outcomes of treatment since Buprenorphine has been approved. Dr. McLellan said there is a lot of data and he would be glad to make those studies available to the Council, but he was unaware if there was any Pennsylvania-specific information.

Mr. Boyle informed Council that 637 Pennsylvania physicians are approved to use Buprenorphine; of that number, 320 are listed on the Substance Abuse and Mental Health Services Administration's (SAMHSA's) website.

Ms. Burks made the point on how important it is to educate this population on how Buprenorphine works. She feels that uneducated patients will misuse the medication and circulate negative communication about it. Ms. Burks agrees with other members of the Council that counseling and follow-up are necessary to assist patients to achieve successful outcomes.

Secretary Johnson questioned the types of support that are necessary for patients to achieve wellness. Ms. Burks remarked that follow-up both in person and phone are extremely helpful to remain active with a client during their treatment process. Dr. McLellan explained that patients need to be involved in a structured treatment program. The services received would include urine testing to check if they are taking their medicine, individual and group counseling, referral for jobs, referral for drug-free housing and becoming involved in an AA or NA group.

Public Comments

Secretary Johnson opened the floor for public comment.

Dr. Flaherty reported how frustrated physicians were when they were unable to have access to Suboxone or Buprenorphine to help patients with treatment during the Heroin/Fentynal epidemic. Dr. Flaherty suggested that the Department needs to discuss ways to help physicians eliminate access barriers. He believes that we must be more detail oriented to make this treatment option work.

From a provider's perspective, Mr. Sarnesco commented on how informed opiate addicts have become. He believes clients want to remain on top of the latest information that affects their progress.

Dr. Charles Morgan commented, "I recently have noticed the drug of choice has become heroin. It used to be alcohol, cigarettes or marijuana." He feels that Buprenorphine will not replace Methadone in treatment; however, Buprenorphine is another alternate. He stated that in order to use Buprenorphine in his program, it requires his program to become a "Modified Narcotic Treatment Program (MNTP)." His only alternative would be to open a private practice office. He commented that it is frustrating not to be able to provide clients what they need and that the Department needs to look at making it easier to use physicians in licensed drug and alcohol facilities.

Ms. Cheryl Floyd commented on medication assisted treatment and how it has been a controversial issue among the recovering community. She feels that the behavior modifications of an addict, through counseling, must be addressed so that in addition to the use of medication there is permanent change within that addict. This will help the addict sustain long-term recovery.

Ms. Berenth Irwin stated that change must occur through support and this will improve the addict's quality of life. Buprenorphine will give a measure of freedom to patients that Methadone treatment cannot.

Dr. McLellan commented that it is wrong not to have these medications available in licensed drug and alcohol facilities. Not having these drugs available in a health setting for treatment of addictions just does not make sense and is not good public health policy.

Ms. Deb Beck supported the need for counseling, in addition to medication as necessary. She also stated that drug-free residential facilities, that wish to remain so, should be able to stay drug-free.

Secretary Johnson thanked everyone for their comments and participation. He said this had helped him understand the different perspectives.

Strategic Prevention Framework – State Incentive Grant (SPF-SIG)

Mr. Boyle reported that the Bureau recently secured a SPF-SIG Five Year Grant totaling $10.4 million dollars. The strategic prevention framework is built on a community-based risk and protective factors approach to prevention and a series of guiding principles that can be utilized at the federal, state and community levels. The SPF requires states and communities to systematically assess their prevention needs based on epidemiological data, build their prevention capacity, strategically plan for and implement effective community prevention programs, policies and practices, and evaluate their efforts for outcomes. The funds enable states, in collaboration with

communities, to implement a process known to promote youth development, reduce risk-taking behaviors, build on assets, and prevent problem behaviors. These grants enable states to provide leadership, support and technical assistance to help ensure that participating communities are successful, as measured by abstinence from drug use and alcohol abuse, reduction in substance abuse-related crime, attainment of employment and/or enrollment in school, increased stability in family and increased access to services.

Jackie Spaid provided Council an overview of the grant to include information on the Bureau's Epidemiology Profile.

Public Comment

Deb Beck asked the Council to intercede in the confidentiality regulation rescission package that is being proposed for the Commonwealth. She is concerned because the administration is allowing third party insurers access to patients' medical histories. She is afraid that patients will not want to go for treatment because their past would be revealed.

Mr. Wambach was concerned as this issue was never brought to the attention of the Council. He also commented that the insurers have become a barrier to treatment. He made the following motion:

> ***I would like to make a motion that a letter be sent from the Advisory Council to the Secretary of Health, the Governor, the House Health and Human Services Committee, the Senate Public Health and Welfare Committee, and the Independent Regulatory Review Commission stating opposition to any changes to the confidentiality regulations of the Commonwealth.***

Mr. Graupera seconded the motion and it was carried five to one.

Mr. Graupera suggested that the Council have a thorough discussion regarding confidentiality in the near future.

Other Business

None

The next Advisory Council meeting will be on April 11, 2007 from 2:00–4:00 P.M. at the Regional Training Institute-Inn at Reading, Wyomissing, PA.

A motion was made and seconded calling for adjournment.

Respectfully submitted,

Janet I. Musser

THE PENNSYLVANIA ADVISORY COUNCIL ON DRUG AND ALCOHOL ABUSE

DATE: April 11, 2007

MEETING MINUTES

In Attendance

Gene R. Boyle, Director, Bureau of Drug and Alcohol Programs (BDAP); and BDAP staff; Maureen A. Cleaver; Robin L. Rothermel; Hector L. Gonzalez; Joseph W. Powell; Terry W. Matulevich; and Ron A. Kauffman.

Members Present

George W. Dowdall, Ph.D.; Trusandra Taylor, M.D.; Peter Wambach; Carlos E. Graupera; Kenneth S. Ramsey, Ph.D.; and Marlene Burks.

Absent

Guy Diamond, Ph.D. and A. Thomas McLellan, Ph.D.

Guests in Attendance

Gail Scott, Reckitt Benckiser; Mark Sarneso, Drug and Alcohol Service Providers of Pennsylvania (DASPOP); Cheryl Floyd, Pennsylvania Recovery Organizations Alliance (PRO-A); Michael Flaherty, Ph.D., Institute On Research, Education and Training in Addictions (IRETA); Dona Dmitrovic and Denise Francis, RASE Project; Joanne Komnier, Alkermes; George Danielle, St. Joseph's University in Philadelphia; Grace Schuyler, Legal Counsel for the Division of Drug and Alcohol Program Licensure (DAPL); and Keith Fickel, Legal Counsel for BDAP.

Welcome and Introductions

Mr. Boyle welcomed the Council members and guests to the meeting and introductions were provided.

Mr. Boyle asked that the January 25, 2007 minutes be accepted by the Council. There was a motion made, seconded and carried to accept the minutes.

Bureau of Drug and Alcohol Programs (BDAP) Update

Mr. Boyle reviewed the previous Council meeting. He reported on meetings he had with Secretary Johnson and Deputy Secretary Grossi. Secretary Johnson requested that Mr. Boyle set up a workgroup that would consist of members of the Council, providers, licensing, legal counsel and researchers in the field. Secretary Johnson wants the committee to address all the issues and barriers brought up by Council. Mr. Boyle stated that he plans to have the committee together by the second week in May. Mr. Boyle expressed the desire to have Council members Thomas McLellan, Trusandra Taylor and Kenneth Ramsey to be a part of the committee. They agreed to do so, along with DOH legal counselors Keith Fickel and Grace Schuyler. As everyone is in agreement that Buprenorphine should be used for treatment, the committee's agenda will include: 1) *How do we make Buprenorphine available?* 2) *What are the barriers that stop us from making it available? 3) How do we remove those barriers?*

The Department, at Secretary Johnson's request, placed the proposed confidentiality changes on the Department webpage, BDAP's webpage and also notified the field with a hard copy. Comments to the proposed regulations were due by March 23, 2007. There were 31 individual comments received on the proposed changes. Program and Licensing staff are presently reviewing these comments.

Mr. Boyle reported that Secretary Johnson brought to the attention of the Governor's Office the motion by Mr. Wambach. Mr. Boyle pointed out that this was the first step in this process and all concerns would be addressed. After challenging the previous motion, Mr. Wambach asked for a *new motion* in the following words:

"I motion that the Secretary of Health send a letter *(in 72 hours)* to the Governor, Department of Health, the House Health and Human Services Committee, the Senate Public Health and Welfare Committee and the Independent Regulatory Review Commission, stating opposition to any changes to the confidentiality regulations of the Commonwealth."

The new motion was unanimously voted by present members and passed.

2007-2008 State Plan/Annual Report

Mr. Gonzalez indicated that Council members were provided copies of the draft State Plan and Annual Report. He then updated on how the new State Plan and Annual Report is compiled by previous year accomplishments and upcoming goals and objectives. He explained the breakdown was by each division and section. He invited the Council to follow along with each report and provide their input. The following BDAP staff provided their division/section reports:

Ms. Cleaver reported on Program Monitoring Division goals.
Ms. Rothermel reported on Treatment Division goals.
Mr. Powell reported on Prevention Division goals.
Mr. Matulevich reported on Fiscal Section goals.
Mr. Kauffman reported on Training Section goals.

Workforce Development Taskforce and Sub-Committee Updates

Ms. Cleaver provided an overview and allowed the four workforce committee leaders to present on their sub-committees.

Administrative Relief Sub-Committee

Mr. Gonzalez reported that this sub-committee was working on additional requirements, mandates and hardships placed on licensed drug and alcohol providers with SCA contracts.

Compensation Sub-Committee

Ms. Cleaver reported that her sub-committee discussed the Department's budget process and how we address the need for additional dollars. She also reported the sub-committee will continue to support loan forgiveness legislation. She mentioned a new initiative called Preferred Provider Contracting. This creates incentives for providers, who receive SCA monies, to receive additional money based on performance measures.

Marketing Sub-Committee

Mr. Powell reported the sub-committee wants to develop a complete package including full continuum of opportunities within the substance abuse profession from prevention, treatment and to include recovery.

Certification/Licensing Sub-Committee

Ms. Rothermel's sub-committee is looking into what degrees are acceptable and how to assure recovering people can enter into the field.

Ms. Burks reminded everyone that the original objective was to find a way to get the recovering population, who is sincere and credentialed, into the field.

Mr. Boyle updated Council that the Block Grant for FY 2007 has been approved. Mr. Matulevich provided a fiscal update and informed Council that the 2008 Block Grant application is due on October 1, 2007.

Ms. Rothermel commented on the Women's and Children's Report, which is required by Act 65. What the report does is outline the capacity for drug and alcohol services for pregnant women and women with dependent children.

Other Business

Mr. Wambach reported on the Act 106 hearing based on the suit by the Insurance Federation. He said Linda Williams, from the Attorney General's Office, did an outstanding job defending our position.
Mr. Boyle reported to Council that Deputy Secretary Grossi was unable to be at today's meeting, because she was meeting with the Governor's Office regarding the mass media campaign on underage drinking.

Mr. Boyle announced Joe Powell would be retiring in June. He thanked Joe for his many years of dedication to the field and to BDAP.

The next Advisory Council meeting will be on Wednesday, June 13, 2007, from 1:00–3:00 p.m. at the Civil War Museum, Harrisburg, Pennsylvania.

Public Comments

Dr. Flaherty wanted to thank the Council for the direction it was moving regarding Buprenorphine treatment.

A motion was made and seconded calling for adjournment.

Respectfully submitted,

Janet I. Musser