

# THE COUNTY OF CHESTER



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KIM P. BOWMAN, M.S.

Executive Director

#2654

January 11, 2008

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

RECEIVED  
2008 JAN 17 AM 10:02  
INDEPENDENT REGULATORY  
REVIEW COMMISSION

Dear Ms. Staloski:

I am writing to provide comment on the proposed amendments to 4 Pa. Code §255.5.

The Department provides a number of reasons why these regulations need to be amended, including better coordination of care and improved system access. However, while the reasons given are laudable, the reality is that nothing in the current regulations prevent coordination of care or access, and the proposed amendments are not only unnecessary, but would erode important privacy and client protections, as well as create more confusion and complexity than currently exists regarding disclosure of client information.

The issue of coordination of care is the one most often raised as why these amendments are necessary. It is raised in the context of coordinating services for the individual, particularly for those with co-occurring issues; coordinating with other systems such as Children and Youth; and coordinating for insurance and benefits. If the issues raised are examined closely, the erosion of important privacy protections as proposed is not justified.

The coordination of care for the individual, particularly for those with co-occurring issues, is in no way restricted under the current 255.5 regulations. There is nothing within the current regulations that restricts service providers from communicating with each other, in great detail, as long as it is done with client consent that meets the federal regulations.

The regulations being amended only impact on a very limited group; insurers, governmental entities, and segments of the Court.

An issue sometimes raised related to coordinated services for the individual is the premise that there is increased complexity in record keeping for programs providing integrated services for people with co-occurring mental health disorders because of the existing regulations. However, there is nothing in the regulations under discussion that prevent providers from having one client record; they only address the level of detailed personal and family information that can be released from that record to the limited entities covered by 255.5. Again, this does not seem to provide justification for eroding essential privacy protections.

Regarding the issue of coordination with systems such as Children and Youth, Pennsylvania's Act 126 of 1998 already addressed this issue. The regulations you are currently reviewing do not apply to any youth or parent where there is an allegation or adjudication of dependency or delinquency. Again, the raising of this issue as a reason to amend this regulation is not applicable and reflects a lack of understanding of current laws/regulations.

The drug and alcohol system has significant partnerships with the criminal justice system yet the proposed amendments to the regulations regarding the Courts and criminal justice system do not reflect this important partnership or provide clear direction regarding Judges, and other essential Court related personnel addressed in the existing regulations. We have one of the longest running treatment courts in the Commonwealth that is built on an extremely strong partnership between the Court and drug and alcohol treatment system. This program has operated successfully under the current regulations and we are in fact expanding the program. Additionally, we conduct several hundred criminal justice assessments for the Courts every year, again under the existing regulations, very successfully.

The issue of increased information to insurance companies as proposed by these amendments is of great concern. We have seen the loss of confidential personal information maintained in databases at both the federal and state level. Therefore, it seems we need to be more careful about what personal information can be disclosed and potentially put into a database, whether it is a commercial insurers, state or federal database.

The proposed amendments would do just the opposite, placing more personal and family data in computer systems and at risk. The amendments, as proposed, would move beyond the already extensive information regarding diagnosis and treatment involvement contained in these data systems. They would expand it to include the private, personal and family information of our citizens (people that potentially could be our loved ones) into these insurance, state and federal databases.

The rationale that by providing insurers with more information we would increase access to care is not logical. This implies that insurers can flaunt existing state laws and regulations, such as 255.5 and use them as a reason to deny care. Additionally, not only is there a significant subjective and impossible to interpret aspect to the proposed amendments regarding what can be provided to insurers (e.g. motivation), it is our experience that the insurers have used this information to deny care rather than provide it.

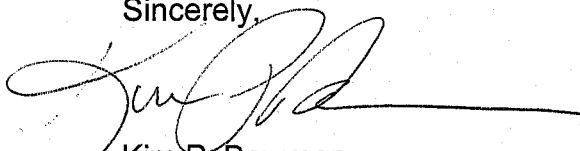
The changes, as proposed, would also create confusion regarding Act 106 of 1989, a law the state has strenuously enforced and that currently is an issue before the Pennsylvania Supreme Court. Given the extensive work by the Commonwealth to insure compliance with this law, it is essential that this not be undermined as would be done by these proposed amendments.

In conclusion, I oppose these proposed amendments to 255.5 as the changes proposed would eliminate important privacy protections for individuals, create more confusion and complexity than currently exists, and are not necessary. They will place individuals at greater risk for reduced access to care and will result in confusion throughout the system due to ambiguity and conflicting interpretations of these regulations.

The enclosed document contains specific comments on each of the portions of the Department of Health Proposed Rulemaking package.

Thank you for your consideration of these comments.

Sincerely,



Kim P. Bowman

KPB/bew  
Enclosure

cc:

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## **Department Proposal Overview**

### **A. Purpose of the Proposed Amendments**

“The Department’s regulations relating to disclosure of client-oriented information have become outdated and an impediment to service delivery and the coordination of care for individuals with substance abuse problems.”

I have not seen information to support this assertion. The regulations being changed only apply to a limited scope of entities (insurers, the Courts and governmental officials), none of whom are or would be involved in the direct treatment of (service delivery to) the individual.

“... the Department has chosen to propose amendments that would protect the interest of the patient in confidentiality of extremely sensitive and stigmatizing personal information, while at the same time providing sufficient information to persons providing treatment and benefits to those individuals, as well as allowing a client autonomy in choosing when and how to release that client’s information.”

Several issues here:

1) This states that this would provide “sufficient information to persons providing treatment” implying that this cannot already occur. Again, the regulations these amendments are proposed for do not apply to treatment providers, so why is this necessary?

2) The proposed amendments provide no protection for clients who do not want this more excessive release of information and eliminate the protections they currently have under 255.5. Additionally, it does not include protection related to access to benefits provided under Pennsylvania’s Act 106 of 1988.

“In general, the intent of the proposed rulemaking is to expand the amount of information treatment providers may release to other entities in accordance with the existing statute, and to clarify for treatment providers and patients what the rules relating to confidentiality and disclosure of patient-identifying information are.”

The proposed amendments actually make the regulations more complex and subjective. From definitions that are incomplete, to allowable information that is extremely broad and subjective, clients and treatment providers will be in the no-win situation of trying to protect privacy, comply with federal and state regulators and satisfy insurers and Courts with unclear regulations and protections.

### **B. Requirements of the Regulation**

Section (c) Consensual Release of Patient Records and Information

4<sup>th</sup> paragraph states "Proposed subsection (c) (2) would make it more difficult for a third party payer to refuse coverage for services on the basis of insufficient information."

This statement is difficult to understand. Given that for most part, the state licenses insurers to operate in Pennsylvania and/or contracts with them to provide these services and has a state regulation that governs the allowable information to be provided to these payers, how could they refuse services based on insufficient information? This implies that the Commonwealth has no authority with those it licenses, approves or contracts with. Are insurers doing business in Pennsylvania not required to comply with state laws and regulations? Does this mean the Commonwealth is allowing insurance companies to use state laws and regulations as a basis for not providing benefits they are contracted for and licensed to provide?

### C. Affected Persons

The Department indicates that these proposed changes would benefit individuals seeking treatment through greater access to services, more appropriate lengths of stay, and improved coordination between various levels and types of care.

The Department does not provide any information to support this conclusion. Contrary to the Department's conclusion, the proposed amendments could in fact, reduce access. For those clients not covered by Act 106 of 1989, there will be more confusion and lack of clarity on what insurance companies can request. If a client is uncomfortable with the amount of information being requested by an insurer and does not want to sign a consent for this amount of information, they may be denied payment for treatment and subsequently, treatment if they are unable to pay themselves under federal regulations. The proposed amendments contain no protections for this. Under current regulations, there are clearly limits to what insurers can request so the patient is not put in the difficult position of needing to choose between essential treatment and allowing excessive privacy infringements.

Additionally, the proposed amendments do not clearly delineate that they would apply only to non-Act 106 of 1989 cases.

Regarding increased coordination of care, there is nothing in the current regulations that prohibit coordination of care. Best practice would be that all direct service providers, involved with a client, consult with each other and insure coordinated planning. The regulations as currently written do not in any way restrict the ability of service providers to communicate fully with each other, as long as they are in compliance with the federal regulations regarding consent.

The regulations for communication between service providers remain the same with or without these amendments. The only change that would be accomplished, via

these amendments, would be for insurers. Given that they are not involved in the direct provision of care, they do not have a need for the same level of information; and there is nothing that prohibits them from requiring that providers communicate with each other.

The Department also indicates that programs would benefit because it would expand the information that could be disclosed to third party payers. It is unclear how this would benefit programs. If state law, in fact, limits what information is deemed appropriate for insurers and this law is enforced by the state with insurers, than why would existing regulation versus these amendments which still contain some restrictions on what insurers can get make any difference?

D. Cost and Paperwork Estimate

The Department states that there would be no measurable fiscal or paperwork requirements. The proposed amendments are more complex than the existing regulation and will be more cumbersome administratively. This will result in increased costs to programs and potentially, for the Department of Health Division of Drug and Alcohol Program Licensure.

Additionally, extensive training will be needed on these amendments if enacted. This training is costly, both in its' provision and in the service interruption it requires for clinicians to attend.

## ANNEX A

### Proposed Regulations

#### a. Definitions:

##### Governmental Officials:

What about other governmental officials that may be involved with the individual in a capacity unrelated to assisting the individual in obtaining benefits or services due to their alcohol or drug abuse or dependence? E.g. IRS, housing authorities....

##### Medical Authorities and Medical Personnel:

Too broad; as written, it appears that this could include any of the medical personnel regardless of whether the individual is receiving or seeking treatment from these individuals. This should specify that it is limited to those defined medical personnel **who are or will providing direct treatment to the individual**. Without some clarification, it appears that it could allow excessive disclosure to insurance company medical personnel.

#### b. Scope and Policy:

This section has dropped employers in the proposed amendment. This was not addressed in the purpose or review of changes in the introduction. Was this deletion intentional? If so why? I am not aware of any problems this aspect of the regulation was creating, so why would we reduce privacy protections?

1. Indicates it applies to records of patients who have received services. This could be construed to mean it applies retroactively to records prior to any changes to the regulations. This should be clarified to state that it applies to records after the effective date of the regulations.

#### c. Consensual Release of Patient Records and Information:

1. Programs may already release information to treating medical personnel with consent. Since this is not prohibited, why is it being included? This is particularly dangerous with the proposed definition of medical personnel, as this could be interpreted to mean that insurance company physicians or medical personnel could receive whole records.

2(i).

This is already covered under federal regulations, why include? How does this differ from 2(ii)? This appears to be independent of 2(ii), so as written appears that those parties referenced could choose to obtain information under 2(i) or 2(ii) and could become very confusing. Given the parties referenced, I am not sure what purpose this could achieve that is not covered under 2(ii). This should not be included.

2(ii).

I have grave concerns about the information that is allowed to be released under this section. Although the Department has indicated that the information reflects the domains of widely accepted level of care criteria, there no protection to insure that it will be used within those frameworks. Experience is that issues such as prior treatment history, motivation... have been used by payers to deny treatment despite the fact that the level of care criteria would actually call for higher levels of care if utilized. Given the lack of protections to guarantee that insurers appropriately utilize the criteria, it is unclear why we would sacrifice privacy rights.

Additionally, although the Department has indicated that the information reflects the domains of widely accepted level of care criteria, the areas outlined do not easily correspond to either the Pennsylvania Client Placement Criteria or the American Society of Addiction Medicine Patient Placement Criteria. Additionally, the proposed areas are overly broad and/or unclear. As written, it would not be clear to the individual what specific information was being released, nor could programs easily interpret it.

For those clients not covered by Act 106 of 1989, insurance companies will likely request excessive information regarding individuals under the guise of medical management, particularly given the lack of clarity in this section. If a client is uncomfortable with the amount of information being requested by an insurer and does not want to sign a consent for this amount of information, they may be denied payment for treatment and subsequently, treatment if they are unable to pay themselves under federal regulations. Under current regulations, there are clearly limits to what insurers can request so the patient is not put in the difficult position of needing to choose between essential treatment and allowing excessive privacy infringements.

Finally, this section needs to clearly acknowledge Act 106 of 1989 and restate that this information cannot be required for Act 106 cases.



3. Disclosure to Legal Representative

Old language was clearer – recommend it be kept. Under new language, what constitutes confirmation of legal representation? Interpretations could get complex. Client signing a consent that indicates the attorney needs the information to provide them representation should be sufficient.

4. Probation/Parole

This is too broad. As written, it appears that probation/parole could get entire record, which would be inappropriate. While it could be argued that this would exceed the information necessary to achieve the purpose, per the federal regulations, even needing to have this argument would put both the client and the provider in a no-win position.

Additionally, this does not address other members of the Courts that may need information regarding an individual's treatment recommendations, involvement and progress related to a client's supervision or acceptance into a diversion or alternative sentencing program based on their participation in treatment. This could include Judges, Bail Agencies, District Attorneys, and prison officials (when related to work release). Again, information that would need to be disclosed would be limited and this needs to be reflected in the regulations.

With the expansion of treatment courts it is essential that this area be clearly defined to insure both successful operation of these programs, clear recognition of the distinct and important roles of the different Court team members, and protection of individual rights.

d. Non-Consensual Release of Patient Records and Information:

These could be confusing because it appears to reflect federal regulations without clearly making the connection. Throughout the section it should reference relevant sections of 42 CFR and insure compliance. For example, (d) (2) relating to disclosure pursuant to an order of a court of competent jurisdiction could state "in compliance with 42 CFR Subchapter A, Part 2, Sub-part E §2.61 through 42 CFR Subpart D §2.67".

(f) Consent Form:

(1)(viii) This is a new requirement and the lack of this component has not been an issue. I would oppose adding new administrative requirements such as this, unnecessarily.

## **REGULATORY ANALYSIS FORM**

### Section 11 - Compelling Public Interest

There is nothing in the current regulations that prohibit coordination of care. The current regulations, without need of amendment, does not in any way, restrict the ability of service providers to communicate fully with each other, as long as they are in compliance with the federal regulations regarding consent. The requirement for communication between service providers remains the same with or without the proposed amendments.

Again, the focus of regulations being changed only applies to a limited scope of entities (insurers, the Courts and governmental officials), none of whom are or would be involved in the direct treatment of (service delivery to) the individual.

Finally, the amendments being proposed go well beyond what was needed to address a simple conflict with the federal regulations. These amendments take what was 3 ½ pages of regulation and turns it into 8 ½ pages that are more complex than the original.

### Section 12 - Risks Associated With Non-regulation

The Department asserts that not making the amendments increase regulatory obstacles. Given the increased confusion and administration that will result from these changes, I would argue that the implementation of these regulations will, in fact, create more obstacles.

### Section 13 - Described Benefit

Again, the Department asserts that individuals would have greater access because insurers could get more information and they would experience improved coordination of care.

Again, this case has not been made. The only way this is true is if the Commonwealth has allowed insurers to disregard or use state privacy protections to deny care. Regarding coordination of care, there is nothing in the regulations being amended that impact on coordination or communication between multiple service providers. The Department itself acknowledges this under Section 14 of this form.

### Section 14 - Adverse Affects

The Department references federal regulations that limit information disclosed to only that necessary to carry out the purpose of the disclosure. (42 CFR, Part 2, §2.13(a). One of the benefits of the existing regulation is that it provides

Comments Department of Health  
Proposed Rulemaking 4 Pa. Code § 255.5  
Kim Bowman, Executive Director  
Chester County Department of Drug and Alcohol Services

detail/clarification to the federal regulations. The proposed amendments provide much less clarity and can result in damage to client and provider.

If a commercial insurer insists on a different interpretation of what is needed and allowed via these proposed amendments, what is the recourse of the provider or the client? The provider will be in a position of being denied payment or putting their license in jeopardy. The client will be put in the position of being denied services/service reimbursement or run the risk of other consequences from too much disclosure. The only one who has nothing to lose and no accountability is the insurer. This is particularly concerning if, as inferred by this package the Commonwealth has no authority in regulating the practices of insurers operating in Pennsylvania.

#### Section 16 - Communication and Input from Public

*In reading the Department's response it appears that they are referencing comment received on a previously considered rescission of the regulations in question; a very different proposal from the current one. I am unclear as to how that would be considered input or communication given that the prior package did not include the proposed amendments in this package. To my knowledge, as an active member of a statewide association, there was no stakeholder involvement in the development of this package.*

#### Sections 20 & 21 - Cost and Cost Benefit

The Department indicates that it does not expect increased costs. I disagree with this assertion. The proposed amendments are more complex than the existing regulation and will be more cumbersome administratively, and therefore, more costly for programs and potentially for Department of Health Division of Drug and Alcohol Program Licensure.

Additionally, extensive training will be needed on these amendments if enacted. This training is costly, both in its provision and in the service interruption it requires for clinicians to attend.