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INDEPENDENT REGULATORY REVIEW COMMISSION

Janice Staloski

Bureau of Community Program Licensure and Certification

Department of Health

132 Kline Plaza Suite A

Harrisburg, Pa 171904

Re: Proposed Changes to the 255.5 regulations

Dear Ms. Staloski,

I first want to thank you for your expedient response to my request for copies of the original DOH Chapter on 255.5 confidentiality regulations. Attached you will find the supporting information of my opposition to the proposed changes to the existing 255.5 confidentiality regulations. I have chosen to use a copy of the draft and insert my concerns in direct relationship to the suggested changes. If you have any questions, please feel free to contact me at 800-255-2335 ext 1204 or lgargano@crchealth.com

Regards,

Laure Rohrs Gargano

LCSW CAC CCDP CETII MAC

Director Research & Development

White Deer Run Inc.

Allenwood Campus

PA CODE- Administration Part XI Governor's Council

On Drug and Alcohol Abuse Chapter 255.5

255.5 Confidentiality of patient records and information:

(a) Definitions: The following words and terms, when used in this section, have the following meanings unless the context clearly indicates otherwise.

Government Officials – Elected or appointed representatives or employees of Federal, State or local government agencies responsible for assisting a patient to obtain benefits or services due to the patient as a result of the patients drug or alcohol abuse or dependence. Government officials include: officers, directors, or employees of non-government entities whose employees are treated, because of their status or other reasons as a government official under applicable federal, state and local law. **COMMENT – This definition is broad in its description of government officials – this needs to be further clarified and be more specific.**

(b) SCOPE AND POLICY:

(4) Unless otherwise permitted by this section, redisclosure of information from a patient record is prohibited unless specifically authorized by the patient. A program that disclosed information from a patient record is a violation of this section may be subject to action to revoke its license or such other penalties as provided by law. This section does not limit any cause of action in law or equity against any person who has disclosed information from a patient record in violation of this section. **COMMENT – the word "redisclosure" can be interpreted to mean that a program can disclose information received from another provider with written consent from the patient. This lack of clarity leaves programs at risk to make interpretive judgment calls in this area. The federal laws prohibit any redisclosure of patient record in section 42CFR –section 2.32 of the federal confidentiality laws. This needs to be clearer in the language used here. There is no such provision for a patient to authorize redisclosure of information in the federal regulations. This is open to interpretation – that a program can receive information from a provider – and then with patient consent forward that protected information to a third program – this places the middle program in a double bind.**

(C) Consensual release of information from a patient records:

(2) part (ii) If the information requested by a government official or third party payor is necessary to determine medical necessity for service admission, continued stay, discharge, referral, concurrent review, coordination of care and payment for services, a program shall limit the information released to the government official or a third party payor to the follow:

(A) A statement of whether or not the patient is in treatment for drug and alcohol abuse or dependence.

(B) The patient's level of intoxication from alcohol, illicit drugs or medication, including the quantity, frequency and duration of use, and any specific withdrawal symptoms exhibited by the patient currently or in the past.

COMMENT: I am concerned how this information will be used to deny services rather than ease access to services at the residential and inpatient levels of care. I have personally experienced commercial insurance carriers as well as health choices carriers deny admission to these levels of care due to clients "not being in a medically threatening condition." When I asked for more information as to what that means – these third party payor and government agents (subcontractors) explain to me that if a patient is not in observable withdrawal then they do not meet the criteria for admission to a detox (residential or inpatient). As many patients seek services while they are intoxicated it is inhumane to expect this patient to wait or to delay admission until such a time that they are in active withdrawal. This is NOT the manner in the medical surgical side of health care makes determinations for admission to hospital based levels of care. I challenge this recommended change you have not sufficiently asserted how this will improve access to services; the quality of those services and improve a treatment outcome. Over the past two decades providers are constantly challenged by funders to more; provide more information; engage in exhaustive credentials processes ~ and now the funders are asserting they need more information. It is my assertion that if a contracted provider has successfully completed and passed the credentialing process – then the provider has demonstrated the competency to admit, assess, set lengths of stays, determine appropriate discharge dates and coordinate care for follow up to a level

of service if appropriate. There are existing quality assurance triggers at every funder to monitor compliance in these areas. I do not understand how disclosure of more information will assist a funder in making a determination. I further assert that if a program is consistently providing substandard care; then the funder is obligated to review records on site of the program and utilize the provider relations and quality assurance guides to resolve those issues. Altering the confidentiality laws will not assure improvements in any of the aforementioned areas. The patient will be the party to experience the consequences. This leads me to address a component of the FAQ"s – there is a statement in the FAQ's that third party payors are not to receive hard copies of records – however the language in the recommended changes is not that clear!! So, I strongly encourage you to enter that specific language into these regulations with that level of clarity and remove the challenge of interpretation.

(C) The patient's vital signs, specific medical conditions to include pregnancy, specific medications taken and laboratory test results. COMMENT – Up to this point, providers have been successful in securing authorization for services without disclosure of the specific vitals. Programs are able to speak in broad terms about vital signs. For example, are vitals elevated, within normal limits or low sufficiently meets the needs of a third party payor as to the status of a presenting patients clinical picture. More details are not necessary to document in their data base. I again believe this information will serve to further support denials of services for those Pennsylvania lives not protected by ACT 106. Within the existing regulations programs are able to release an Axis 1-5 diagnosis - which would include medical conditions. This alteration is unnecessary for determining medical necessity for a medical and EMOTIONAL/BEHAVIORAL disease.

(F) The patient's risk level for resuming substance use, abuse or dependence based on patterns of use, relapse history, existing relapse triggers and coping skills to maintain recovery.

COMMENT – Under the current guidelines programs are already permitted to review most of this information; however what can be discussed is much more restrictive. Someone competent in the provision of substance abuse treatment generally concurs that if a recovering person uses any substance without a prescription from a physician has relapsed. How exactly does the specificity of frequency, amounts, and substance involved assist in determining if funding is appropriate? The larger clinical issue is the fact that a person has relapsed. Again here, the FAQ's have failed to adequately support how disclosure of this information will improve access to services, the quality of services and improve outcomes of treatment services. All this does to this point is to serve the third party payors desire for more information. I am unable to find any link to substantiate how disclosure of this information serves the purpose asserted by Secretary Johnson in April and I quote "I want this process to be transparent and to review how these changes will improve the quality of service for those two thirds of Pennsylvania residents not protected by ACT 106"

There has been nothing specifically offered in the draft or the FAQ's to support these assertion that these changes will improve services. There are multiple references as to how these changes will serve to meet the needs of the third party payors! These regulations are for the protection of the patient; their intent has never been to make the payment process easy for the payors!! We have clearly lost sight of that point in this process.

(6) A program may disclose information from a patient record, without the patients consent, to persons reviewing records on a program premises in the course of performing audits or evaluations on behalf of any federal, state, or local agency which provides financial assistance to the program or is authorized by law to regulate it's drug and alcohol abuse or dependence treatment activities; or on behalf of any third party payor providing financial assistance or reimbursement to the program or performing utilization or quality control reviews of the program. COMMENT: This sounds to be in contradiction of the FAQ's which make a very clear statement that charts may not be released to a third party payor. The above statements appear to conflict with the clarification in the FAQ's. A provision in the standards regulating the insurance industry in Pennsylvania already allows a third party payor the opportunity to review records. Under those guidelines the insurer needs to present themselves to the program site. I can attest to the reality that in twenty years I have yet to have a third party payor present themselves to a

program campus for this purpose. Few of the health choices contractors have presented on site to review charts though this has slowed significantly in recent years. Further, I am deeply concerned about that statement that a release is not required in order to perform utilization functions. The lack of clarity in the wording of the above could permit a third party payor to interpret the above statement to mean that utilization review of client information for the purpose of admission; continued stay and discharge reviews can be performed without a consent to release information.

(F)Consent Form: Number 1 thru 7 are already covered in the DDAPL regulations for program licensure, I do not understand the need to restate what is required by licensure here? Number 8 however is a new idea.

(8) A place to record oral consent to release of information given by a patient physically unable to provide a signature and a place for the signatures of two responsible persons who were in the presence of the patient and witnessed that the patient understood the nature of the release and freely gave oral consent. **I honestly cannot think of any circumstance where a patient is unable to physically sign a release of confidential information? Medical emergencies have a contingency exception and this is the time I imagine would prevent someone from physically signing a release of information. The above statement fails to adequately define who is a responsible person? To permit a verbal release of information will place programs at risk for difficulty with licensure and patients/patient families. I need a better explanation of the thought process that supports this permission being added to the existing regulations.**

This concludes the specific areas I object to in these proposed standards. I cannot imagine what the real motivations are for making these changes. There has been no open disclosure as to where this process even started. I am curious who is behind the effort to force these changes through the process with inadequate review of the field at large. As I sat in the audience on April 16th and listened to those in support of these changes I realized how poorly informed some are in this area of their practice. Doctors were concerned about prescribing a medication to a patient that they are allergic to and the resulting potential consequences; I am curious under what circumstances a doctor is prescribing medications? If the patient can speak – then I assume some basic historical information would be gathered before a doctor takes liberty to write a script! If the patient is unresponsive or unconscious then the medical emergency exclusions cover a program to release information for the purposes of medical treatment! What frustrates me further is that physicians can have access to complete records if needed! Only those that work for the third party payor cannot have the record! So I am most confused why this is an issue?

No one in any of the meetings I attended in regard to this matter mentioned the current regulations already have an existing avenue to release information above and beyond what 255.5 allows. It is the section pertaining to the executive director of a program having the right to exceed these regulations. I will gladly quote the standard for ease of reference from page three of DOH 255 Management Information, Research and Evaluation; (7) *Projects may disclose information as set forth in subsection (b) with the consent of a client, in writing, to an insurance company, health, or hospital plan or facsimile thereof, which has contracted with the client to provide or will provide medical, hospital, disability or similar benefits. In the event that an insurance company, health or hospital plan remains dissatisfied with the content of the information release with regard to a client in accordance with this paragraph, such insurance company, health or hospital plan may apply to the Executive Director for additional information with the written consent of the client and, upon approval by the Executive Director, said information may be released."*

As I read the above quote from the existing regulations, I find myself further puzzled as to why this push is occurring now? I find myself asking these questions: Who do these changes really benefit? (The funders not the patients) What is the gain of these changes? (An over release of information to third party payors who have no treatment obligation to their member – that falls completely on the provider; and the more information released the greater the opportunity to deny care) How will expanding what can be discussed with a third party payor assist the patient? (I have not been able to formulate a benefit to the patient at all) How will giving a third party payor more information really serve to demonstrate the quality of care concerns Secretary Johnson spoke of in the meeting on April 16th? As I see it, there are no causative or performance links between release of confidential information and the improvement in quality of services to patients. these recommendations for change clearly serve one entity – the third party payor!

I reiterate here the same stance I have held since I attended my first meeting about this in January. I believe that the regulations in Pennsylvania should be applauded not only by Pennsylvanians – but by all the other states as well!! In an environment where YouTube defines what is personal and what is public, over disclosure of personal information is occurring among our teens at rates faster than what our legislative bodies (state and federal) can keep pace with; this is NOT the time to ease our standards. In an era where cyber bullying is rampant in our schools; reality television programs form our standard of what is entertainment and acceptable to place on national/international television; and identify theft continues to climb; and our own government is incapable of securing veteran's personal data ~ I assert that the need to preserve the integrity of a person's confidential medical information is more urgent now than ever. Our counter parts in other states are feverishly trying to gain what we as a state have already been graced to have in place. The foresight and intuitive awareness of those who formulated these regulations, were decades ahead of their time. The crafters of these regulations had to have known what was looming in our future not only in substance abuse treatment but the health care system at large. This group took the necessary steps to ensure that Pennsylvanians would have complete and comprehensive coverage to protect those seeking to recover from this fatal illness.

So, I challenge you as the leadership of substance abuse industry in Pennsylvania to stand by the regulations as they are currently written. Do not succumb to the belief that third party payors need more; do not fall prey to the tails of medical necessity determinations warrant this information! Those are the lies spun by the very industry that has our nation's health care system in such embarrassing disarray for a country such as the United States. At some point government will need to take the stand against the powerful health insurance industry and set standards that genuinely serve the patient and not the mulit-billion dollar per year industry known as our health care system. Stay the course, trust what I suspect the majority of those reading these proposed changes know intrinsically to be truth – these changes are being urged by the third party payor; serve the third party payor and will preserve the dollars in their pockets! All the while, those who are suffering from this fatal illness will suffer grave losses in protection of the personal information. Deliver the message to the third party payors and their messengers that you can see through their thinly veiled attempt to get more. Once you concede these changes I can guarantee you one thing – there will be more concessions in the future. Concessions in: disclosure parameters; length of stay; admission rates; availability and access to appropriate levels of care – stop this shell game the insurance industry has created with the health care of our residents! The decision you make with regard to these changes will impact over six hundred thousand Pennsylvanians. I can only hope you are clear in understanding the profound impact these changes will have on our substance abuse industry in this state.

Sincerely,

Laure Rohrs Gargano

LCSW CAC CCDP CETII MAC

Director Research & Development

White Deer Run Allenwood Campus

▶Fax 2654

7/21/2008

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Comments:

Attached is my letter in opposition to the proposed changes to the 255.5 regulations.

Regards,

Laure Rohrs Gargano

(total # of pages including fax cover 6)

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