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**RECOMMENDATIONS OF
SUBSTANCE ABUSE LEGAL WORK GROUP**

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Substance Abuse Legal Work Group

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OVERVIEW

This memorandum summarizes the work product of the Substance Abuse Legal Work Group (“SALWG”) and addresses the following questions:

1. What barriers does current Illinois law present to establishing and operating a state-wide health information exchange (“HIE”) that allows for the integration of substance abuse patient information with primary care patient information?
2. What are the recommendations of the SALWG to allow for the integration of substance abuse patient information with primary care patient information in a HIE?

In answering the above questions, the SALWG applied the principle adopted by the Illinois Health Information Exchange Legal Task Force Executive Committee (the “Executive Committee”): the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) would provide the baseline for use and disclosure of health information utilizing the HIE, subject to restrictions imposed by federal confidentiality laws and regulations.¹ Therefore, the SALWG developed recommendations that predominantly focus on the gaps between 42 C.F.R. Part 2, HIPAA, the Illinois Mental Health and Developmental Disabilities Confidentiality Act (“IMHDDCA”), and current Illinois law as it relates to the protection of substance abuse patient information.

LEGAL LANDSCAPE

The Federal Confidentiality of Alcohol and Drug Abuse Patient Records law reflects Congress’ longstanding concern that individuals not be made more vulnerable as a result of seeking treatment for a substance use disorder. Concerns about stigma and discrimination against people who receive substance use disorder treatment are as real now as they were when the statute was enacted in 1972. It remains important to take exceptional care to protect the privacy of people who seek treatment for addictions.

Yet the nation’s health delivery system has changed, and there is a national interest in promoting the coordination of health services delivered by multiple providers and in implementation of electronic health records.

Under the current statutory and regulatory framework, physicians and case managers cannot access any information about an individual’s substance use disorder treatment covered by the 1972 federal confidentiality law without specific written authorization, except in cases of emergency. This creates communication barriers that limit the ability of health care providers and health plans to identify and conduct outreach to people who may be receiving duplicative or

¹ 42 U.S.C. 290dd-2; 42 C.F.R. Part 2.

inappropriate treatment and coordinate care of persons who may be at significant risk. This directly impacts patient care and safety.

The SALWG debated the balance between the need to facilitate communications in support of the delivery of coordinated health care with the need to protect the privacy interests of persons who seek treatment from substance use disorder treatment programs.

Current law only protects addiction treatment information in certain settings. Confidentiality requirements for addiction treatment information apply only when that information is contained in a record held by a federally-assisted “program”. In other words, addiction treatment information given in a general hospital, emergency room, physician office, federally qualified health center, or rural clinic generally would not receive heightened protections.

In Illinois, the Alcoholism and Other Drug Dependency Act (“AODADA”)² sets forth the confidentiality protections for patient records maintained in connection with any program relating to alcohol or other drug abuse. AODADA largely traces the federal substance abuse confidentiality restrictions. In addition to the AODADA, the SALWG reviewed a number of other statutes and regulations.³

BARRIERS TO HIE

Our Illinois community-based behavioral health system of care is a critical component of our overall health care system. The addiction treatment system, including community providers and peer and prevention specialists, must be allowed to fully participate in the HIE to the same extent as the general health care delivery system. The behavioral health system must also be financially incented to use interoperable electronic health records (“EHR”), just like the physical health care delivery system. This would undeniably lead to: (a) a reduction in emergency room utilization, (b) the provision of specialty care for detoxification, (c) better health outcomes, (d) increased economic productivity, a reduction in public safety costs, and an increase in the effective use of the overall healthcare system, and (e) financial savings through community-based care.

However, there are specific legal and other barriers to establishing and implementing the state-wide HIE, including the following:

- 1. Historic, Outdated Laws.** There are legal barriers to the exchange of sensitive patient data between Illinois substance abuse treatment providers and physical health providers. Specifically, there are federal laws (42 U.S.C. 290dd-2) and corresponding federal regulations (42 C.F.R. Part 2), enacted in the early 1970s, that deal with confidentiality specific to substance abuse treatment, diagnosis, and referrals that the Illinois statutes, including AODADA, trace. These laws, regulations and statutes contain stringent protections for addiction treatment that are

² 20 ILCS 301/30-5.

³ Hospital alcoholism patient records security policy, 77 Ill. Adm. Code 250.2860(f); facility substance abuse patient records security policy and disclosure permitted to medical personnel in a medical emergency, 77 Ill. Adm. Code 2060; Consent by Minors to Medical Procedures Act, 410 ILCS 210/4, 5; Firearm Owners Identification Card Act, 430 ILCS 65/4(2), (3), /8; and Illinois Controlled Substances Act, 720 ILCS 570/318.

premised on the negative stigma historically associated with substance abuse and the assumption that individuals would be more motivated to seek treatment if they were assured that it would remain confidential.

2. **Lack of Financial Resources.** Many small behavioral health providers do not have the resources to purchase and implement EHR systems.
3. **Lack of Financial Incentives.** Behavioral health providers are not financially incented to purchase and implement EHR systems like their physical health counterparts.
4. **Knowledge Gaps.** Substance abuse treatment providers and patients alike are not well-informed about the benefits of a HIE and the use of EHRs.
5. **Legal Barriers.** Legal barriers and confusion about privacy and exchange of sensitive patient data exist between Illinois behavioral and physical health providers.

RECOMMENDATIONS

The following are the recommendations of the SALWG that would allow substance abuse treatment information to be shared in a HIE.

1. ***RECOMMENDATION 1:*** **Promote Change at the Federal Level and Operate Within Confines of Federal Restrictions.** The Federal Confidentiality of Alcohol and Drug Abuse Records law was enacted in 1972 to protect the privacy of individuals who receive treatment for substance use disorders. Over the last forty years, our country's health delivery system has evolved significantly. As a result, there is a mounting push for the coordination of health services and the implementation of EHRs. However, under the present statutory and regulatory structure, healthcare providers are prohibited from accessing any information about a patient's substance use disorder treatment without specific written consent, except in certain defined instances. Unfortunately, this structure impedes the ability of healthcare providers to determine whether a patient may be receiving improper or duplicative treatment or to coordinate care of patients whose health may be at risk, thus negatively impacting patient care and safety.

Because federal substance abuse confidentiality laws and regulations are outdated and hinder Illinois' ability to facilitate a greater level of coordination of care that we believe the HIE can achieve, the SALWG would like to see them revised to accurately reflect the current state of the addiction treatment field. However, such a change would require Congressional action. Until the federal law is updated, we are restricted in Illinois from making necessary changes to our own state statute. Thus, for purposes of our HIE, the most effective way to enable the exchange of information through a HIE is pursuant to written patient consent, which is required except in instances such as the following: (a) medical emergency⁴, (b) for research purposes⁵, (c) for audit

⁴ 42 C.F.R. §2.51.

⁵ 42 C.F.R. §2.52.

and evaluation purposes⁶, (d) pursuant to a court order⁷, or (e) pursuant to a qualified service organization (“QSO”)/business associate (“BA”) agreement⁸.

We recommend revising Illinois laws to be consistent with HIPAA, where possible, while staying within the confines of the federal substance abuse confidentiality regulations at 42 C.F.R. Part 2. In doing so, we would work within the parameters established by the Substance Abuse and Mental Health Services Administration (“SAMHSA”) and the Office of the National Coordinator (“ONC”).

2. RECOMMENDATION 2: Institute Safeguards and Penalties. Recognizing that even limited disclosures could create a risk of improper use of information, we propose to ease concerns about the amount of addiction treatment information that would be shared through a HIE by instituting a number of safeguards to address these fundamental vulnerabilities. Neither federal nor state law expressly includes discrimination prohibitions or protections. We would add to AODADA patient protections addressing penalties for discrimination and improper use and disclosure of sensitive addiction treatment information. Legal remedies for violations of 42 C.F.R. Part 2 are currently limited to a \$500 criminal penalty, with additional violations allowing for increases of up to \$5,000. These amounts do not serve as deterrents to improper use of substance abuse records or resulting discrimination. We would strengthen financial penalties and other remedies available under Illinois law for improper use or disclosure of sensitive information. Robust provisions would be included that would: (a) prohibit discrimination on the basis of information in substance use disorder program records, (b) limit use in criminal and civil investigations or proceedings (discussed further in Recommendation 6 below), (c) strengthen civil and criminal sanctions against unauthorized disclosure, and (d) provide individuals the right to pursue civil remedies against persons who violate the statute and include attorneys’ fees.

Additional discussion is needed concerning continuing fears regarding sharing substance abuse treatment information within a HIE. Specifically, issues related to the length of time the information will be retained and the number of individuals who will have access to the information must be addressed.

3. Medical Emergency Exception. Substance abuse treatment information may be disclosed in the case of a medical emergency “to medical personnel who have a need for information about a patient for the purpose of treating a condition which poses an immediate threat to the health of any individual and which requires immediate medical intervention.”⁹ Immediately following the disclosure, the program must document the disclosure in the patient’s records, including the name of the medical personnel to whom disclosure was made and his or her affiliation with any healthcare facility, the name of the individual making the disclosure, the date and time of the disclosure, and the nature of the emergency.¹⁰

⁶ 42 C.F.R. §2.53.

⁷ 42 C.F.R. §2.61-2.66.

⁸ 42 C.F.R. §2.11.

⁹ 42 C.F.R. §2.51(a).

¹⁰ *Id.*

RECOMMENDATION 3: Broadly Construe Medical Emergency. To the extent the HIE legislation specifically includes a medical emergency exception, we recommend that the statutory language defining medical emergency be as broad as possible.

Pursuant to 42 C.F.R. Part 2, substance abuse treatment providers are required to document when disclosures of patient substance abuse treatment information are made for emergency purposes. This exception to 42 C.F.R. Part 2, often called the “breaking the glass” exception, is a helpful and necessary exception, but is required to be implemented in a very impractical way. Specifically, under the medical emergency provisions, patient identifying information may be disclosed for purposes of treating a condition which poses an immediate threat to the health of *any* individual and which requires immediate intervention. When a disclosure is made in connection with a medical emergency, the *Part 2 program* must document in the patient’s record the name and affiliation of the recipient of the information, the name of the individual making the disclosure, the date and time of the disclosure, and the nature of the emergency.¹¹

In an emergency situation, it is generally the EMT, emergency room doctor, or other hospital personnel who make the decision to “break the glass” and use the patient’s substance abuse treatment information. The substance abuse treatment provider has neither knowledge of, nor control over, when the actual step to “break the glass” occurs. Yet, the provider is required to document the disclosure. Not only does this make no sense, it exposes the provider to needless liability by holding the provider responsible for an action over which it has no control.

RECOMMENDATION 4: Create an Alert System. We recommend that the HIE provide a mechanism such that when a treating provider triggers the medical emergency exception, an alert gets distributed to the appropriate covered program so that it may be able to properly document the disclosure and comply with 42 C.F.R. §2.51(c).

4. Standard State Consent Form.

A. RECOMMENDATION 5: Develop Standard State Consent Form. We recommend developing a standardized state consent form that meets the requirements of the federal substance abuse confidentiality regulations at 42 C.F.R. Part 2, as well as Illinois laws including AODADA and IMHDDCA.

B. RECOMMENDATION 6: Rewrite the IMHDDCA. SAMHSA released another set of FAQs in December 2011 that provided very useful guidance concerning patient consent. SAMHSA clarified issues about selective revocation, redisclosure, merger or corporate restructure of a disclosing program, QSO agreements, use of a single consent for different recipients for different purposes, and the medical emergency exception. This information makes it easier to envision a functional standardized state consent form. However, questions still remain about the feasibility of developing such a form, given the need to incorporate the consent requirements of the IMHDDCA that are far more restrictive than those contained in 42 C.F.R. Part 2 and AODADA.

¹¹ 42 C.F.R. §2.51(c).

The current IMHDDCA represents a patchwork of legislative drafting in response to changes in the behavioral health field over the past forty years. It contains stringent provisions that severely limit the flexibility required to develop a standardized state consent form that would allow behavioral health providers to participate in a HIE. Specifically, the IMHDDCA as it is currently written: (a) requires patients to specify a calendar date as the expiration date of their consent, as opposed to an event such as “upon my death” as recommended by SAMHSA; (b) requires that, in addition to the patient, a witness must also sign the consent; (c) requires that, in addition to the patient, a witness must also sign a revocation, and that any revocation must be in writing; (d) contains an ambiguity with respect to blanket consents in that the meaning of “unspecified information” is unclear; and (e) contains strict provisions with respect to advance directives.

The IMHDDCA thus serves as a roadblock to the development of a standardized state consent form that can be used to share substance abuse and mental health patient information in the Illinois HIE. We therefore recommend that the IMHDDCA be rewritten in its entirety, using HIPAA as a model wherever possible. In doing so, we would include adequate mental health patient protections and anti-discrimination provisions. This restated IMHDDCA should be crafted with the input of key behavioral health associations, provider groups, consumers, advocates, government leaders, and other experts in the field in order to gain broad consensus and support.

In addition to our specific comments, we embrace and support the recommendations contained in the Behavioral Health Legal Work Group memorandum for changes to the IMHDDCA.

C. *RECOMMENDATION 7:* Use “Upon My Death” as Expiration Event or Condition. Another concern is that a consent must include a date, event or condition upon which it expires.¹² Without this, the consent is invalid. This could pose a problem where a consent expires without the HIE or HIE members being notified, thereby creating a scenario where patient information may continue to be shared without authorization from the patient. SAMHSA suggested in its December 2011 FAQs that the statement “upon my death” be used as the event or condition upon which a consent would expire. This would avoid the scenario described above and we would encourage this statement to be used by the HIE. In fact, perhaps this condition should be added to a standardized consent form as a matter of course. However, this proposed solution under 42 C.F.R. Part 2 and the AODADA may work, but would currently violate the IMHDDCA. The expiration event or condition should be taken into account in the rewrite of the IMHDDCA.

D. *RECOMMENDATION 8:* Include Comprehensive List of Disclosure Purposes. Further, there is concern that a consent authorizing disclosure for “treatment” purposes would not allow the sharing of addiction treatment information for purposes such as payment, disease management, or quality improvement activities. We therefore recommend the consent be reviewed to specifically include a comprehensive list of items

¹² 42 C.F.R. §2.31(a)(9).

that may be disclosed, any categories of information needed by the HIE and its members, such as disclosure for payment purposes, disease management, quality improvement services, etc.

5. RECOMMENDATION 9: Preserve Stringent Court Orders. Addiction treatment information is of potential interest to law enforcement, child welfare, employers and attorneys in civil proceedings. Therefore, it is essential that any proposed changes to current law maintain strong confidentiality protections. We recommend preserving the extensive due diligence provisions for court orders for substance abuse treatment information consistent with 42 C.F.R. Part 2.

6. RECOMMENDATION 10: Limit Use of Information in Criminal and Civil Investigations. We recommend retaining special due process protections of court orders required under 42 C.F.R. §§2.61-2.66 and 20 ILCS 301/305(bb), which prohibit the use of treatment information in criminal and civil proceedings by the government without a specific court order and include the exclusion of evidence as a remedy for illegally obtaining or wrongfully using confidential treatment information.

7. Fund Behavioral Health EHRs. Behavioral health facilities, unlike their physical health facility counterparts, are not eligible to participate in the American Recovery and Reinvestment Act meaningful use incentive payment program. Additionally, many small addiction treatment providers in Illinois do not have the resources to purchase and implement EHR systems. We therefore recommend making funding available for addiction treatment providers to allow them to use EHRs.

A. Meaningful Use Incentive Payments. On July 15, 2010, the Centers for Medicare and Medicaid Services (“CMS”) announced its final rule concerning EHR incentive payments for “meaningful users”. “Meaningful users” are defined as eligible professionals, eligible acute care hospitals and critical access hospitals. An “eligible professional” is defined as an MD, DO, DDS, Nurse Practitioner, Certified Nurse Practitioner, or Physician Assistant (if practicing in a FQHC). As the law stands, behavioral health facilities do not qualify as “meaningful users”. Consequently, they are not eligible to receive incentive payments directly from the government. Because EHRs and the HIE are in some ways interconnected and because the participation of behavioral health facilities is desirable to carry out the HIE objectives, these entities should not be subjected to additional hardship when it comes to acquiring these meaningful use incentive payments.

The only mechanism for behavioral health facilities to receive incentive payments is via a voluntary reassignment by their employed or contracted eligible professionals. An eligible professional may assign their *full* EHR incentive payments to only *one* employer/entity.¹³ In order for an eligible professional to qualify for the Medicaid EHR incentive payment, the eligible professional must have a minimum of 30% of his patient volume attributable to patients receiving Medicaid.¹⁴ A “Medicaid encounter” means

¹³ See 42 C.F.R. §495.10(e).

¹⁴ See 42 C.F.R. §495.304(c)(1).

services rendered to an individual on any one day where Medicaid paid for part or all of the service or Medicaid paid for part or all of an individual's premiums, co-payments and cost-sharing.¹⁵

Assuming CMS does not amend the definition of "meaningful users" to include behavioral health facilities, the following are recommendations that are designed to make it easier for behavioral health facilities to obtain meaningful use incentive payments. Note that each of the following recommendations presumes that: (a) the eligible professional has reassigned his EHR incentive payments to the behavioral health facility pursuant to a valid contractual arrangement that permits the behavioral health facility to bill and receive payment for the eligible professional's services, and (b) the reassignment does not violate applicable Medicare/Medicaid laws or Stark and Anti-kickback laws.¹⁶

1. **RECOMMENDATION 11:** We recommend that the State of Illinois permit eligible professionals to count as part of their "Medicaid encounters" Medicaid services provided to a patient by ancillary non-eligible professional providers (i.e. counselors, clinicians, etc.) for purposes of calculating the eligible professionals' 30% patient volume requirement.

2. **RECOMMENDATION 12:** If Medicaid services are provided to a patient in an addiction treatment setting where the facility bills for the per diem service or outpatient counseling delivered by other professionals authorized under the Illinois Department of Human Services, Department of Alcoholism and Substance Abuse ("DASA") Rule 2060 which are approved in a treatment plan authorized by the eligible professional (the physician), then the State of Illinois should allow that patient to count as part of the 30% Medicaid patient volume for the eligible professional.

3. **RECOMMENDATION 13:** If Medicaid services are provided to a patient by a non-employed eligible professional (i.e. a physician assistant) but are billed through the behavioral health facility's employed or contracted eligible professional (i.e. the supervising MD), then the State of Illinois should allow that patient to count as part of the 30% Medicaid patient volume for both professionals.

B. RECOMMENDATION 14: Expand Health Information Technology Incentives to Behavioral Health. We recommend that the State of Illinois expand Medicaid incentives available to substance abuse providers. Illinois should support SB539 (Sen. Whitehouse D-RI), a bill reintroduced to expand federal health information technology payments to mental health professionals, psychiatric hospitals, mental health treatment facilities and substance abuse treatment facilities.

¹⁵ See 42 C.F.R. §495.306(e)(1)(i).

¹⁶ See 42 C.F.R. §495.10(f)(1).

8. ***RECOMMENDATION 15: Institute Administrative and Technical Safeguards.*** We understand that several administrative safeguards are already being considered to protect the privacy of behavioral health patients within the HIE, and that these safeguards would apply to substance abuse disorder information, as well as to other records, such as HIE consents. We propose that anyone accessing the HIE also enter into an agreement setting forth requirements, as well as specific civil or criminal penalties, for unauthorized access or use of information within the HIE.

In addition, certain technical safeguards should be put in place to protect the privacy of behavioral health patients. Currently, 42 C.F.R. Part 2 only addresses physical file protection (i.e. records should be stored in locked rooms and in locked file cabinets).¹⁷ The technical safeguards found in HIPAA should be equally applied to substance abuse treatment records in electronic format.

Consistent with the recommendations of the Executive Committee, we believe that there should be steps taken to facilitate public trust. Some of these steps would include: establishment of breach notification monitoring, auditing of compliance, increased Illinois penalties for violations, as well as implementation of HIPAA security requirements.

¹⁷ See 42 C.F.R. §2.16.

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