AHPA
ADVENTIST HEALTH
POLICY ASSOCIATION

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Roger Severino
Director
Office for Civil Rights,
Department of Health and Human Services,
Docket HHS-OCR-0945-AA00,
P.O. Box 8013,
Baltimore, MD 21244-8013

Docket HHS-OCR-0945-AA00; Request for Information on Modifying HIPAA Rules To Improve Coordinated Care

Dear Mr. Severino,

On behalf of the Adventist Health Policy Association (AHPA), we appreciate the opportunity to provide a response to the Office of Civil Rights' (OCR) Request for Information (RFI) on Modifying the Health Insurance Portability and Accountability Act (HIPAA) to Improve Coordinated Care. Our organization of five Seventh-day Adventist affiliated health systems includes 84 hospitals and more than 300 other health facilities in 17 states and the District of Columbia. Our patients reflect the communities we serve; diverse in age, race, ethnicity, income and payor. With such diverse facilities, populations served and geographical locations, we strive to provide an objective and sound policy voice that functions across health care providers.

AHPA supports OCR's interest in improving coordinated care. Below, please find AHPA's comments and recommendations in response to the RFI. Specifically, we comment on the following:

- Protected Health Information (PHI) Disclosure between Covered Entities
- Promoting Parental and Caregiver Involvement and Addressing the Opioid Crisis
- PHI Disclosure between Covered Entities and Non-Covered Entities
- Timely Disclosure of PHI for Treatment, Payment and Health Care Operations
- Minimum Necessary Requirement for Care Coordination and Case Management Disclosures
- Health Care Clearinghouses
- Notices of Privacy Practices (NPPs)

PHI Disclosure between Covered Entities

The Department of Health and Human Services (HHS) is considering changing the rule language that currently permits covered entities to share PHI with other covered entities to instead mandate disclosure of information. OCR poses the following question: Should covered entities be required to disclose PHI when requested by another covered entity for the purposes of treatment, payment or health care operations?

AHPA opposes any requirement that mandates the disclosure of patient data across the health care industry as we believe such an obligation conflicts with preserving patient privacy rights. If covered entities were required to disclose PHI to every covered entity that requested the information, patients would lose control over the use and disclosure of their information. The resources involved to make mandated disclosures would be a significant increase. Furthermore, in many states, obtaining consent from a patient to disclose his or her information is required under state law.

AHPA urges OCR to influence an amendment of the federal substance abuse law's (42 U.S.C. § 290dd-2) regulations (42 CFR Part 2). The single greatest obstacle to sharing information among providers is the lack of alignment between 42 CFR Part 2 and HIPAA. Although changes have been made, 42 CFR Part 2 remains a burden because the privacy protections travel with the information. This differs from HIPAA and other confidentiality laws that recognize information recipients may not be subject to the same privacy restrictions as the entity that disclosed the information. Furthermore, the law is more restrictive than HIPAA and requires additional consent prior to the disclosure of substance use information. This additional restriction leaves providers with limited information and inhibits providers' ability to make the best possible decision about a patient's clinical care. Obtaining multiple consents from a patient is challenging and creates administrative barriers to providing timely, whole-person treatment.

Promoting Parental and Caregiver Involvement and Addressing the Opioid Crisis

The OCR seeks comments on whether changes should be made to allow greater access to the treatment information for parents of adult children and between spouses. Additionally, OCR inquires whether to allow adult children to access the treatment records of their parents in certain circumstances, especially in cases where an adult child is not the parent's personal representative.

AHPA does not believe that broadened regulatory authority is necessary. Rather, AHPA urges OCR to identify a standardized process for promoting parental and caregiver involvement and encourage states to adopt this process. HIPAA specifies how an individual may involve a family

member or friend into their treatment and provides guidance to providers in clarifying this involvement. Moreover, state laws outline the appointment of personal representatives. In cases where the individual has not designated a personal representative, many state laws detail the process providers should follow to identify which family member is best suited for the role. The intersection of HIPAA and state requirements (which vary from state to state) often obscure clarity on this issue.

PHI Disclosures between Covered Entities and Non-Covered Entities

Currently, HIPAA covered entities are permitted, but not required, to disclose PHI to a health care provider who is not covered by HIPAA. Non-covered entities include health care providers that do not engage in electronic billing or other covered electronic transactions. Under HIPAA, covered entities may share PHI for the purposes of treatment and payment with either the covered entity or the non-covered health care provider. Through the RFI, OCR poses the following question: Should a HIPAA covered entity be required to disclose PHI to a non-covered health care provider? Additionally, would such a requirement create any unintended adverse consequences?

AHPA opposes any requirement that mandates the disclosure of patient data with non-covered entities. The requirement would necessitate additional regulations outlining the circumstances for mandated disclosure and create additional administrative burden for both the requestor and the responder. Each request would need to be evaluated to determine if it met the definition of mandated disclosure. The covered entity receiving the request would also need to set up a new administrative process to confirm the identity of the requester.

AHPA believes that the liability associated with the mandated disclosure of PHI to providers that are not subject to HIPAA's privacy and security protections is significant. The risk to providers outweighs the benefit of convenience to the patient. Patients currently have access and can request all PHI from their individual health care providers.

Timely Disclosure of PHI for Treatment, Payment and Health Care Operations

OCR proposes requiring providers to deliver PHI in a *timely manner* upon request. The term ‘timely manner’ was not specifically defined within the RFI. The OCR seeks feedback on the amount of time it takes for covered entities to provide an individual with a copy of their PHI when requested pursuant to the individual's right of access at 45 CFR 164.524. OCR also queries whether the length of time to provide the PHI varies based on whether the medical records are maintained electronically or in paper.

Additionally, it seeks input on whether the length of time varies based on the type of health care provider or plan.

AHPA recommends that OCR maintain the current 30-day window for providers to disclose PHI for treatment, payment and health care operations. We commend OCR for seeking to make the process of data disclosure more efficient. However, filling a record request is not as simple as obtaining the information and releasing it to the requestor. Whether records are in paper or electronic form, they must be reviewed to ensure there is no additional or unnecessary data included prior to disclosure. Supplementary data must be properly redacted before a record can be released. The ability to provide PHI is also dependent on many variables, such as how the records are maintained, the provider and plan type and even the amount of time it takes to receive test results (which varies by test).

Minimum Necessary Requirement for Care Coordination and Case Management Disclosures

OCR seeks comments on how the Privacy Rule should be modified to comply with the HITECH Act. The Act requires that accounting of disclosures include those made for treatment, payment and health care operations through an electronic health record. Specifically, the RFI inquires: Should OCR expand the exceptions to the Privacy Rule's minimum necessary standard? How can exemptions be granted without becoming overly burdensome? Examples of possible exemptions include: Population-based case management and care coordination activities, claims management, review of health care services for appropriateness of care, utilization reviews and formulary development.

AHPA believes the current minimum necessary standard is sufficient because it allows covered entities to determine and document that the entire medical record contains the minimum necessary amount of information needed for population health activities.

Health Care Clearinghouses

OCR proposes to allow health care clearinghouses to provide PHI to individuals upon request. They argue that since health care clearinghouses typically receive PHI in their role as business associates of other covered entities, they would be able to provide an individual access to that PHI as well. OCR believes that granting this authority to clearinghouses may be useful to individual. Citing that the change would allow individuals to obtain their full treatment history, pulled from a variety of health care providers without having to separately request PHI from each health care provider.

AHPA opposes the notion that health care clearinghouses should be subject to individual access requirements. Often, health care clearinghouses do not maintain PHI for extended periods of time, a complete designated record set, or even access to health provider's paper records. To provide accurate information to patients, clearinghouses would need to maintain a complete record set for extended periods of time. Furthermore, they would need to implement a mechanism for changes and updates to PHI, and a process for communicating with other health care providers so the patient would obtain the entire designated record set. Moreover, these entities traditionally do not communicate with individual patients. The aforementioned issues would prevent clearinghouses from being able to immediately operationalize patient requests. Subjecting clearinghouses to individual requests would result in increased administrative burden, which would drive up the clearinghouse costs to health care providers and health plans.

OCR made an additional inquiry regarding clearinghouses. They pose the following question: If health care clearinghouses are not required to enter into business associate agreements with the other covered entities for whom they perform business associate functions, should the requirement also be eliminated for other covered entities when they perform business associate functions for other covered entities?

AHPA commends HHS for working to create parity in the compliance requirements of HIPAA. AHPA believes the Business Associate Agreement (BAA) allows the OCR to reach third parties that were not granted direct authority to regulate in the HIPAA mandate. This means that ensuring privacy obligations is appropriate and currently serves its intended purpose well. However, covered entities that are already subject to HIPAA should not be required to enter into a BAA. The BAA requirement between two covered entities is duplicative and unnecessary.

Notices of Privacy Practices (NPPs)

The NPP is a document that informs patients, employees, or clients how their health information may be used and shared and lists their health privacy rights related to PHI. A covered entity's NPP must inform individuals of the right to obtain an accounting of disclosures. The OCR poses the following questions regarding the NPP: Is this notice sufficient to make patients aware of this right? If not, what actions by OCR could effectively raise awareness?

AHPA believes the NPP is sufficient to make patients aware of their right to obtain an accounting of disclosures. However, the maintenance of NPPs pose an unnecessary administrative burden on providers. AHPA urges OCR to eliminate the requirement that covered entities keep NPPs on file with patients' medical records. HIPAA not only requires that NPPs are updated at least every three

years, but NPP document itself must be kept on record by the covered entity for up to ten years. This requirement is overly burdensome and should be eliminated.

Conclusion

AHPA commends HHS for seeking to address the regulatory burden associated with compliance to health privacy law. AHPA welcomes the opportunity to further discuss any of the recommendations provided above. If you have any questions or would like further information, please do not hesitate to contact me at Carlyle.Walton@AdventistHealthPolicy.org or Julie Zaiback-Aldinger, Director of Public Policy and Community Benefit, at Julie.Zaiback@AdventHealth.com.

Sincerely,

Carlyle Walton, FACHE
President
Adventist Health Policy Association