

February 12, 2019

Roger Severino
Director, Office for Civil Rights
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue, SW
Washington, DC 20201

Subject: Request for Information on Modifying HIPAA Rules to Improve Coordinated Care (RIN 0945-AA00), 83 Fed. Reg. 64302 (Dec. 14, 2018)

Dear Mr. Severino:

On behalf of our more than 400 member hospitals and health systems, the California Hospital Association (CHA) appreciates the opportunity to respond to the request for information (RFI) published by the Office for Civil Rights (OCR) about Health Insurance Portability and Accountability Act (HIPAA) privacy and security rules. CHA supports OCR's goals of removing regulatory obstacles and decreasing administrative and regulatory burdens to facilitate efficient care coordination and promote value-based health care. We urge HHS to move quickly to put patients first by implementing rulemaking and/or additional subregulatory guidance in each of the three areas noted below. It is unfortunate that, in addition to the challenges at the federal level, providers in California must also navigate complex patient privacy and disclosure laws at the state level; these divert precious resources from patient care due to their inherent cost. We strongly believe that the federal government can lead by example in identifying and working to remove requirements that are no longer relevant and have not met their intended goals. We look forward to working with OCR to bring about this change in 2019. The following specific comments are provided for your review and consideration.

Disclosures for Treatment and Care Coordination Purposes

CHA believes that the HIPAA privacy rule provides adequate authorization for disclosures for treatment and care coordination purposes. However, as OCR notes, "some HIPAA covered entities have expressed reluctance to share this information for fear of violating HIPAA." The complexity of the HIPAA privacy rules, coupled with potential fines in the millions of dollars for violations (breaches), has created fear throughout the health care field and a mindset that patient information should be shared as little as possible in all circumstances. We agree that patient privacy should be our priority. To that end, hospitals and health systems spend millions of dollars investing in training and technology to protect patients. However, we — as a health care field — need to think differently about how we accomplish our goals of care coordination and seamless transitions, which are in patients' best interests, while still respecting the delicate nature of information that is shared.

CHA urges a three-pronged approach to solve this problem: (1) simplify the privacy rule in general; (2) repeal potential fines for inadvertent, good-faith breaches; and (3) expressly permit, in regulation, disclosure of patient information without patient authorization to caregivers and family as well as other health care providers, social service agencies, and community-based support programs, including homeless shelters, domestic violence shelters, free clinics, schools, food banks, immunization registries, frequent user databases, and other recipients as needed to provide services to individuals. The minimum necessary rule should expressly not apply to disclosures to these entities. Instead, a “professional judgment” standard should apply. In addition, we urge the agency to delete the regulatory references to “psychotherapy notes.” The adoption of provisions related to psychotherapy notes has not increased patient privacy at all. It has instead led to misunderstanding of the privacy rule with respect to mental health records (most people believe that all mental health records are “psychotherapy notes,” which is incorrect) and to psychotherapists creating duplicate files for patients.

Furthermore, provisions of 42 C.F.R. Part 2, relating to individuals receiving services from substance use disorder (SUD) programs, have created a huge barrier to providing high-quality, coordinated care to these individuals. These regulations restrict sharing of SUD information, which often denies clinicians treating patients with a SUD access to their complete medical histories. The only way to properly treat the whole person is to have all the information about the whole person. For example, knowledge of a patient’s prior SUD history is essential to proper pain management after surgery.

To ensure compliance with 42 C.F.R. Part 2, clinicians must maintain two separate computer systems and two separate medical records. This requirement adds burden and expense, but without benefit. CHA supports efforts to make statutory changes that would amend 42 C.F.R. Part 2 to align with HIPAA for the purposes of treatment, payment and health care operations.

As a general principle, CHA does not support different regulations for different types of medical information: mental health, substance abuse, genetic information, or any other category. This leads to complexity, misunderstandings by patients and providers, and mistakes.

As mentioned above, CHA supports expanding the exception to the minimum necessary standard to uses and disclosures for population-based case management and care coordination activities. The minimum necessary standard leads health care providers to fear appropriate sharing of patient information, because health care professionals are concerned that their interpretation of “necessary” might not be correct, and they will be punished for an inadvertent breach.

Business Associate Agreements

OCR requested input (question 18) about whether covered entities should be required to enter into agreements with social service agencies to be allowed to disclose patient information to them. As mentioned above, we agree that social service agencies are strategic partners in care transitions and we must find ways to share appropriate information. However, we disagree that the business associate agreement is an appropriate regulatory avenue in which to accomplish this goal. Moreover, CHA believes that OCR should revisit the current business associate provisions and strongly consider repealing a significant number of them. Now that business associates must comply with many of the privacy and security rules, the requirements related to written agreements are unnecessary and only add costs to our health care system. Extending these requirements to additional entities is inefficient and onerous; CHA

believes there is a better way to accomplish our goals. We urge the agency to continue to think creatively with stakeholders about how to reduce paperwork and keep our focus on the patient.

Accounting for Disclosures

CHA applauds OCR's recognition that its proposed accounting of disclosures rule issued in May 2011 would create undue burden for covered entities without providing meaningful information to individuals. We support OCR withdrawing the notice of proposed rulemaking. Most patients are not interested in seeing a report of every disclosure made by a hospital for treatment, payment, and health care operations purposes. Instead, a request for an accounting of disclosures usually comes about because a patient believes that he or she was the subject of a breach. The current complaint process affords a better mechanism for meeting the patient's request. It is a tested process and one that we believe limits duplicative efforts of providers.

CHA supports allowing providers to require individuals who request an accounting of disclosures to describe the exact nature of their interest or concern for which the report is requested. For example, a hospital prepared extensive accounting at the request of a patient who claimed unauthorized access of his information. When the findings were presented to the patient, he then stated that what he **really** wanted to know was whether a particular family member employed by the hospital had viewed his record. If the hospital had been allowed to require (rather than only request) that the individual state the specific nature of his inquiry at the outset, the hospital could have narrowed and focused its review, saving innumerable hours of staff time — and better serving the patient.

Notice of Privacy Practices

Existing regulations require that covered providers with a direct treatment relationship try to obtain a signed acknowledgement of receipt of the providers' Notice of Privacy Practices (NPP). This process was "intended to provide an opportunity for the individual to review the NPP, including the individual's privacy rights, to discuss any concerns related to the privacy of her or his PHI, and to request additional restrictions or confidentiality of communications." While well intended, it has resulted in more burdensome and unproductive paperwork — and has left patients feeling overwhelmed and irritated by being asked multiple times to sign yet another form. Information contained in the NPP can be displayed on a provider website and easily accessed at the patient's convenience. Requiring patients to sign a form acknowledging receipt of information they can find through a routine Google search is duplicative and, again, not a good use of scarce health care resources.

We appreciate the opportunity to provide our comments. If you have any questions, please do not hesitate to contact me at akeefe@calhospital.org or (202) 488-4688, or my colleague, Lois Richardson, vice president and counsel, privacy and legal publications/education, at lrichardson@calhospital.org or (916) 552-7611.

Sincerely,

/s/

Alyssa Keefe

Vice President Federal Regulatory Affairs