



February 12, 2019

Roger Severino
Director, Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Re: Request for Information on Modifying HIPAA Rules to Improve Coordinated Care [RIN 0945-AA00]

Submitted via e-mail: www.regulations.gov

Dear Director Severino:

The California Association of Public Hospitals and Health Systems (CAPH) appreciates the opportunity to respond to the Office for Civil Rights' request for information on how to improve guidance under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to improve care coordination. As health care systems that care for some of our state's most vulnerable patients, including coordinating their services across multiple systems of care and human services agencies, we appreciate and support OCR's efforts to remove barriers to coordinated, efficient care while maintaining important patient privacy protections.

California's 21 public health care systems play a central role in the state's safety net and health care landscape, delivering care to all who need it, regardless of ability to pay or circumstance. Although they represent six percent of all California hospitals statewide, they serve 2.85 million Californians each year and provide more than 10 million outpatient care visits each year. Public health care systems provide 35% of all hospital care to the Medicaid (Medi-Cal in California) population in their communities and provide nearly 40% of all hospital care to the state's uninsured residents. They serve hundreds of thousands of Californians as their chosen source for primary, specialty, and hospital care. Public health care systems fill multiple and significant health care delivery roles, which have a profound impact on the health of millions of Californians. It is through this lens that we respectfully offer the comments below.

- 1. OCR should affirm that existing HIPAA definitions already encompass the ability to disclose protected health information (PHI) to social services agencies and community-based support programs (Questions 18-21).**

We appreciate OCR's recognition that "some individuals, such as those experiencing homelessness or suffering from chronic conditions, including serious mental illness, receive care from a variety of sources including HIPAA covered entities, social service agencies, and community-based support programs." Our member health systems are essential safety net providers for these vulnerable populations, and administer many programs designed to manage and coordinate their care. Based on our experiences,

we agree with OCR that “[c]oordinating the care and related services” for these individuals “requires sharing PHI among those involved.”

We do not, however, believe that the creation of a new regulatory permission to disclose PHI to social service agencies and community-based support programs is the most effective way to facilitate sharing PHI for care coordination and related policy goals. Instead, we urge OCR to affirm the scope and flexibility of existing regulatory authorities. We are concerned that layering on an additional exception to the already complicated web of health-information privacy rules risks increasing confusion and uncertainty rather than promoting effective information sharing.

HIPAA’s treatment exception allows a covered entity to share PHI for the “provision, coordination, or management of health care and related services” (45 C.F.R. § 164.501 (defining “treatment”)). On its face, the treatment exception is broader than just traditional “health care” services, as it encompasses other “related services.” When social and behavioral services are furnished in connection with a health care provider’s care coordination or case management program that addresses health-related social and behavioral needs, the treatment authority squarely covers many of the specific examples described in the RFI, such as disclosure to an agency that arranges for housing near a specific health care provider to facilitate a disabled individual’s health care needs. We urge OCR to affirm that these services may be “related services” for purposes of HIPAA’s treatment exception. In the modern health care environment, it is increasingly common for health care providers to coordinate and manage multidisciplinary care teams that include social workers and other community-based support programs. Not only are these models of care supported by public health research focusing on the social determinants of health, they are endorsed and promoted by other federal government agencies, such as the Centers for Medicare & Medicaid Services.

We believe that clarifying the flexibility and scope of existing regulations would help avoid unnecessary complexity. As it stands today, and as OCR notes in the request for information, the barriers to information sharing imposed by HIPAA are often barriers of perception — overburdened covered entities may be reluctant to make disclosures that are permissible under the regulations because they do not have the time or resources to thoroughly analyze the issue. This problem is exacerbated by myriad other privacy laws, including but not limited to 42 CFR Part 2, confidentiality provisions related to eligibility in Medicaid and other programs, criminal justice laws, and state statutes, which often must be considered alongside HIPAA before a disclosure may be made. The reality is that navigating privacy laws means untangling complicated questions of statutory and regulatory interpretation involving the interplay of state and federal laws that rarely line up neatly. Adding new HIPAA authorities for specific categories of individuals will increase the complexity of that analysis, and could further undermine confidence in the broader-based exceptions that are somewhat easier to understand and more likely to be consistent across laws.

Furthermore, multidisciplinary care teams and innovative treatment models that address the social determinants of health are constantly evolving. We are concerned that narrowly targeted permissions to promote sharing with specific individuals and entities in identified circumstances would inevitably lag behind, frustrating important efforts to innovate or improve care coordination activities for patients.

In light of these considerations, we believe it would be most effective for OCR to confirm the flexibility of widely used authorities that already exist, such as the permission to disclose PHI for treatment activities, and to communicate clearly that such authorities are broad enough in scope to meet the treatment needs of patients and modern health care providers.

2. OCR should remove the minimum necessary requirements for population-based care coordination and case management (Question 17).

Increasingly, policy makers and providers are focused on two critical areas of work: (1) improving population health through outreach and prevention, including addressing the needs of the “whole person” by taking into consideration health-related social needs when delivering health care services, and (2) coordinating those services among multiple entities. To be effective in these areas, providers need access to comprehensive data sets. Population health management requires that providers collate multiple data sources into dynamic disease registries and risk algorithms that are used to understand health trends, identify gaps in care, and assess opportunities for outreach and prevention. Whole person care requires that providers access a broad spectrum of information beyond clinical data, including data about patients’ social, medical, and economic conditions. Often these data sets live in disparate places and must be shared and combined to create a complete picture of the patient, so that providers and care teams can effectively coordinate care.

Historically, the “minimum necessary” requirement meaningfully circumscribed the PHI that covered entities shared for population-based care coordination and case management because those activities were limited in scope and primarily focused on specific medical events. However, in the new world of prevention, population health, and health-related social need, and with enhanced technological capabilities to leverage rich data sets, it is no longer obvious how to determine the “minimum necessary” PHI for effective population health management. Rather than a sensible protection of patient privacy, the minimum necessary standard has become an undue burden that can undermine effective population health management that can improve patient outcomes. Thus, while policies that advance population health and whole person care are pushing providers to share more data, HIPAA pulls them in the opposite direction and creates fears that could result in underuse of data, and therefore less efficient and effective care.

As the field evolves toward population health and whole person care, regulations regarding minimum necessary must evolve too so that providers can become more effective in helping patients achieve their health goals. **CAPH supports removal of the minimum necessary requirements for these types of disclosures.**

3. OCR should delay implementation of a requirement for a covered entity to provide patients with an accounting of disclosures for treatment, payment, and health care operations (Questions 27-42).

CAPH appreciates that OCR is seeking ways to implement, in the least burdensome way, a requirement from the Health Information Technology for Economic and Clinical Health (HITECH) Act (Pub. L. 111-5) that covered entities be able to account for disclosures made for treatment, payment, or health care operations (TPO). The HITECH Act specifies that the accounting would apply to disclosures made through an electronic health record (EHR) during the three years before the request. We continue to believe that the administrative burden of implementing this requirement is still too great relative to the frequency of requests received, and ask that OCR continue to delay implementation. As large public health systems that serve nearly 3 million people each year and provide more than 35% of hospital care to the Medi-Cal beneficiaries in the counties in which we operate (with those counties covering about 80% of California residents), our systems receive anywhere from zero to less than five requests in any given year. Some systems reported going multiple years without receiving a request. Yet complying

with this requirement would be more burdensome for certain systems than is justified by the small number of requests received each year.

California's public health care systems are in various stages of EHR implementation. Most systems have integrated EHRs, but four are in the process of transitioning to such a system this year; two will still not have an integrated EHR by 2020. Systems reported that they would struggle with meeting the three-year look back prior to implementation of the EHR since they would not have had the opportunity to collect the necessary information through that EHR, but the law seems to hold the entity accountable based on the date that the electronic EHR was acquired. For systems that are currently migrating, the roll out process is highly structured and lengthy, making midstream modifications nearly impossible.

Because the capabilities of EHRs vary widely by vendor, even some systems that have implemented EHRs would need to request modifications to be able to comply with the disclosure requirements. For instance, one system can only account for reports printed, what part of the chart, and for whom, and that changing such requirements would involve engaging the vendor to investigate which elements can be captured with the existing solutions. Some systems would also need to modify their systems to distinguish between uses and disclosures, and that even with modifications, disclosures made to entities outside of their EHR system would need to be documented manually.

Furthermore, as commenters have expressed in the past, accounting for all TPO disclosures could result in large data dumps that are not meaningful to patients. Many of our hospitals have physicians on staff who are not part of the same covered entity as the hospital because they are employed by outside academic institutions. A patient with a handful of visits or stays thus could end up receiving a long list of treatment disclosures for what appeared to the patient to be an interaction with a single covered entity. We question the utility of such an accounting. ***Because of these multiple and significant concerns, we urge OCR to delay implementation of the accounting of disclosures for TPO.***

4. OCR should not impose a new mandatory disclosure obligation (Questions 6-16).

The request for information asks whether health care providers "face barriers or delays when attempting to obtain PHI from covered entities for treatment purposes," and if so, whether converting the authority under the Privacy Rule to disclose PHI to health care providers for treatment purposes into an obligation would eliminate the current barriers and improve care coordination and case management. While our members sometimes experience barriers or delay in receiving PHI from other health care providers for treatment, a mandatory disclosure obligation would not address the root cause of these barriers and would only increase the burdens imposed on covered entities.

Delays in receiving PHI for treatment are often caused by technological limitations or incompatibilities. For example, certain facilities, although they have an electronic health record, refuse to use the software's capabilities to share medical records for treatment, instead relying on fax machines to exchange requests and records. This practice may be driven by security concerns about linking electronic systems to outside entities or legacy business practices that have not been reconsidered in years.

In other cases, barriers exist because facilities follow standard workflows that require patient authorization prior to disclosure of PHI, whether or not the disclosure would be permitted by HIPAA's treatment or health care operations authorities. Facilities often justify restrictive workflows based on the complexity of complying with multiple privacy regimes. Many states, including California, have

enacted their own health information privacy requirements for general medical information, substance-use-disorder treatment records, mental health information, STI test results, and/or genetic information, and health care providers in some cases choose to rely on patient authorizations as the simplest method for ensuring legal compliance with the combined obligations of state and federal law.

We are concerned that making disclosures for treatment mandatory under HIPAA without resolving these barriers will create new burdens on covered entities. If such a rule were promulgated, it would mostly serve to increase the legal risks threatening covered entities: overdisclosing PHI could trigger lawsuits, regulatory penalties, or state or federal prosecutions, while failure to disclose PHI could invite civil money penalties or corrective action plans. This more punitive environment would not further the goals of patient safety or privacy. **We ask OCR not to propose a new mandatory disclosure obligation, and instead to further investigate and remove barriers to sharing PHI, exploring alternatives to incentivize appropriate and beneficial disclosures.**

We recognize the significant challenge of modernizing and streamlining HIPAA and thank OCR for exploring this issue. Please feel free to contact us if you have any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Jackie Bender". The signature is fluid and cursive, with the first letters of each word being capitalized and prominent.

Jackie Bender
Vice President of Policy, CAPH