May 6, 2021

Robinsue Frohboese  
Acting Director, Office of Civil Rights  
U.S. Department of Health and Human Services  
Hubert H. Humphrey Building, Room 509F  
200 Independence Ave. SW  
Washington, DC 20201

RIN 0945-AA00—Proposed Modifications to the HIPAA Privacy Rule To Support, and Remove Barriers to, Coordinated Care and Individual Engagement

Dear Acting Director Frohboese:

Thank you for the opportunity to comment on the above-captioned proposed rule. America’s Essential Hospitals appreciates the work of the Department of Health and Human Services (HHS) Office of Civil Rights (OCR) to propose revisions to the Health Insurance Portability and Accountability Act (HIPAA) privacy and security regulations that might hinder care coordination. We support the agency’s work to improve the delivery of high-quality care across the health care continuum and reduce regulatory burdens that impede essential hospitals’ ability to fully engage in care coordination.

America’s Essential Hospitals is the leading champion for hospitals and health systems dedicated to providing high-quality care to all, including the underrepresented. Our more than 300 member hospitals fill a vital role in their communities. They provide a disproportionate share of the nation’s uncompensated care, and three-quarters of their patients are uninsured or covered by Medicare or Medicaid. Essential hospitals provide state-of-the-art, patient-centered care while operating on margins one-third that of other hospitals—2.5 percent on average compared with 7.6 percent for all hospitals nationwide.¹

The high cost of providing care to low-income and uninsured patients leaves essential hospitals with limited financial resources. Even with their limited means, our member hospitals demonstrate an ongoing commitment to serving patients who face social and financial hardships. Essential hospitals provide specialized services that their communities otherwise would lack (e.g., trauma centers, emergency psychiatric facilities, burn care); expand access with extensive networks of on-campus and community-based clinics; furnish culturally and linguistically appropriate care; train health care professionals; supplement social support services; and offer public health programs.

Essential hospitals regularly meet the complex clinical and social needs of the patients who come through their doors. Our members provide comprehensive ambulatory care through networks of hospital-based clinics that include onsite features—radiology, laboratory, and

pharmacy services, for example—not typically offered by freestanding physician offices. Their ambulatory networks also offer behavioral health services, interpreters, and patient advocates who can access support programs for patients with complex needs.

1. **Modification to increase permissible disclosure and right of access** should align the definition of electronic health record across agencies; provide flexibility for covered entities to exercise judgment in allowing individuals to record health information at the point of care; and maintain existing timeliness requirements for responding to access requests.

Members of America’s Essential Hospitals understand patients need to be active participants in their care plans to avoid unnecessary readmissions, mitigate chronic conditions, and help make choices that fit their financial, physical, and emotional goals. Individuals should have the right to access their personal health information (PHI) in a manner that is secure, convenient, and useful in coordinating care and meeting these individual health care goals, while not adding burden to provider workflow or inviting unintentional security breaches.

a. **OCR should limit the EHR definition to more closely align with the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act) definition.**

OCR should narrow the definition of EHR to align with the HITECH Act and limit it to clinical and demographic data. OCR proposes to define EHR as:

> ...an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff. Such clinicians shall include, but are not limited to, health care providers that have a direct treatment relationship with individuals, as defined at § 164.501, such as physicians, nurses, pharmacists, and other allied health professionals. For purposes of this paragraph, “health-related information on an individual” covers the same scope of information as the term “individually identifiable health information” as defined at § 160.103.

OCR acknowledges this definition is more expansive than the definition in the HITECH Act; this definition is overly broad and would require providers to produce voluminous amounts of data. The proposed definition includes not only clinical and demographic data, but also billing data, which are not always stored in the same EHR system as clinical data. Providers are not currently equipped to provide this data to patients through view-download-transmit functionalities of an EHR, which are limited to clinical data. Given the breadth of data in OCR’s proposed definition, requests for PHI could require multiple data export queries involving dedicated hospital staff to process and perform these requests. The sheer volume of the data inevitably will burden providers and could disrupt provider information technology (IT) systems.

Further, we are concerned about language in the definition stating that clinicians “include, but are not limited to” health care providers that have a direct treatment relationship with individuals. This vague qualifying language vastly expands the types of providers that could create or manage data in an EHR, including potentially those without a clear connection or treatment relationship to the patient. **OCR should remove the phrase “but not limited to” or clarify what other types of providers could be included in this definition.**

OCR proposes to define a new term in the HIPAA privacy rule—“personal health application” would be defined as “an electronic application used by an individual to access health information about that individual in electronic form, which can be drawn from multiple sources, provided that such information is managed, shared, and controlled by or primarily for the individual.” In other words, the covered entity does not manage or control the information, like in a patient portal; rather, the individual controls this information (e.g., vital signs, weight).
b. OCR should permit covered providers to allow patients to record their PHI at point of care but also to implement safety measures to prevent data breaches, including providing PHI in other formats, instead.

OCR proposed to create a new right of access allowing individuals to view and capture PHI through means that include note-taking, videos, and photographs. OCR also proposes that covered health care providers are not permitted to delay the right to inspect when PHI is “readily available at the point of care” (e.g., during a visit). There must be a balance between allowing broader access to PHI for patients and the burden on providers to ensure privacy protection and security at the point of care.

Recent cybersecurity threats in the health care space, including through ransomware attacks on providers, are a reminder of why we must ensure new rights of access are secure before rushing into implementation. Once PHI is placed on an individual’s device, it is exposed to a potential breach. OCR must ensure adequate guardrails to protect PHI from a breach; these guardrails will be critical to ensuring patient privacy and secure capture of confidential patient health information. For example, OCR would not require a provider to allow an individual to connect a personal device, such as a thumb drive, to the covered entity’s information systems. We agree and encourage OCR to provide additional guidance on other conditions and limitations providers could apply to avoid security breaches. Further, **OCR should give providers flexibility in implementing policies, including the choice to bar individuals from recording PHI at the point of care if there is a comparable alternative, without fear of violating the HIPAA privacy rule.**

Essential hospitals believe in providing individuals access to their PHI; policies developed by a covered entity to safeguard this process should not impose unreasonable barriers to individual access. **However, it is critical an individual accesses an accurate and complete record.** By allowing an individual to view and capture PHI (note-taking, videos, photographs, etc.) at the point of care, there is a risk the individual could capture incomplete or inaccurate information and mistakenly rely on such information.

**Additionally, we urge OCR to consider the potential disruptions to a covered entity’s operations and the risk of capturing sensitive information beyond the patient’s PHI (e.g., other patients, workforce members).** For example, there might be workflow issues related to compliance with these requests at the point of care. Providers might need to extend a visit without prior notice, and an additional process might be required for inspecting and approving a device used by an individual to capture PHI. Further, individuals might experience technical issues with their personal devices and could ask providers to troubleshoot the problem. For this reason, OCR should provide clearer guidance for determining when PHI is “readily available.”

OCR also seeks comment on whether to permit covered entities to deny in-person inspection of PHI when necessary to protect the health or safety of the individual and other health care personnel (e.g., during a pandemic). **In these limited instances, we support OCR’s recommendation that covered entities provide copies of PHI in lieu of in-person inspection.**

c. **OCR should maintain the existing privacy rule timeliness requirements for responding to access requests.**

OCR proposes to shorten from 30 to 15 days the timeframe for responding to access requests. Essential hospitals respond to requests promptly, and typically within the current timeline for requests. However, the proposed shortening of timeframes does not account for the variety and volume of requests received and what is required for response. While health IT has the potential to facilitate more rapid delivery of PHI when requested, some access requests still will require a
manually process (i.e., physically stored PHI). Given the variation of requests, differences in form and format of PHI, and complexity of technologies and other requirements, we do not support shortening the timeframe for responding to access requests.

2. OCR should allow other government agencies and stakeholders to make progress toward interoperability before mandating that covered entities share PHI electronically with third parties, including other providers.

HHS has conducted important work to promote new technology for providers and encourage increased information exchange across providers. As directed by the 21st Century Cures Act, ONC in April 2019 released the second draft of the Trusted Exchange Framework and Common Agreement (TEFCA), which outlines a set of principles for trusted exchange and is intended to enable interoperability. In addition to creating the TEFCA, HHS issued rules implementing requirements of the 21st Century Cures Act—including on information blocking and application programming interfaces (APIs) that affect the way providers exchange patient information across the care continuum. Due in part to the COVID-19 pandemic, ONC and CMS delayed implementation of key provisions of these rules.

Specifically, CMS’ regulation addressed interoperability and patient access, while ONC’s cross-cutting regulation addressed interoperability and information blocking. This rulemaking provided much-needed clarification on how providers share information with one another and with their patients to improve care coordination, but it left many other questions unresolved.

We support HHS’ efforts to improve interoperability among providers, as well as the use of EHR technology to improve the information flow between providers and patients. However, it would be premature for OCR to propose HIPAA modifications related to the electronic exchange of information when stakeholders still are implementing requirements of these rules. HIPAA modifications not aligned with implementation timelines for the CMS and ONC rules could confuse providers and patients. We urge OCR to review the provisions of the CMS and ONC rules related to interoperability and API, and to determine how those proposals might impact proposed changes to HIPAA. OCR should examine potential HIPAA modifications to achieve alignment across the agencies, including by ensuring proposed HIPAA changes are aligned with implementation timelines of the ONC and CMS rules.

3. HHS should allow development of standards and guardrails on the use of APIs and personal health applications before mandating the production of PHI through such applications.

OCR seeks comment on the use of APIs as a means for providers to give patients PHI access through mobile applications. While we appreciate the potential of APIs to allow patient access to PHI, much work remains for the Office of the National Coordinator for Health IT (ONC) to develop certification criteria ensuring APIs meet program requirements and have mature standards. The Centers for Medicare & Medicaid Services (CMS) and ONC have taken some steps in their interoperability rules that would create standards for the use of APIs. However, serious privacy and security concerns remain about the use of APIs and third-party applications. Cybersecurity threats to providers underscore the need to ensure these new capabilities are secure before rushing into implementation; OCR must thoroughly vet these issues before APIs are ready for widespread use.

America’s Essential Hospitals supports the concept of leveraging APIs to improve information exchange among providers and with patients. Making patient information available to third-party applications, however, could implicate grave security and privacy concerns. As OCR notes in the rule, personal health applications are not governed by the HIPAA privacy and security rules. While ONC is working on standards for APIs, there are no guardrails for how third-party applications are to leverage and secure patient data once they have received the data through
the API. Due to the proliferation of mobile applications, a patient could request access through any application that has not been thoroughly vetted and is new to the market; this could lead to privacy and security risks. In fact, recent breaches of mobile application data in the health care and personal fitness sectors demonstrate the privacy and security risks involved with sharing information through third-party applications.¹ One recent report underscored the risks involved with popular mobile health applications, finding that of the 30 examined, all were susceptible to breach of PHI due to vulnerabilities with the APIs.² For these reasons, we urge OCR to allow development, maturation, and implementation of API and third-party application security standards before mandating that providers adopt APIs and share information through personal health applications.

4. OCR should modify its proposal that oral requests be actionable when directing copies of PHI to a third party.

Requests to direct an electronic copy of PHI in an EHR must be in writing, signed by the individual, and clearly identify the designated person and where to send the copy.⁴ OCR proposes a written access request would be one means of exercising the right of access, but oral requests also would be actionable if the request is “clear, conspicuous, and specific.”

The replacement of the existing requirement with a standard that, in part, relies on the requester conveying information clearly and completely, and the provider understanding and receiving that information accurately, is troublesome. While the intent of allowing oral requests is to provide flexibility, there could be unintended consequences and inequity associated with requests that are unclear, missing information, or misinterpreted. By nature, oral requests might omit key information that would be included in written requests, which typically rely on a standard form. Providers will need to identify the appropriate third party recipient of the data if that information is not provided orally by the patient, or is unclear, and then take the added step of confirming this information with the patient. This could increase burden for providers in processing requests for transmission of data to third parties.

Further, for patients of essential hospitals with limited English proficiency (LEP), oral requests might be inconvenient and could require additional resources and support (e.g., interpreters). OCR should ensure modifications to improve right of access do not have the unintended consequence of creating disparities among certain populations. We urge OCR to permit oral requests not as a requirement, but as an option to increase flexibility for hospitals.

5. OCR should finalize its exception to the “minimum necessary” standard for disclosures for individual-level care coordination and case management.

We support OCR’s proposed exception to the “minimum necessary” standard, which will facilitate care coordination and the provision of value-based care, such as through alternative payment models. The privacy rule generally applies a “minimum necessary” standard such that covered entities are required to use, disclose, or request only the

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⁴ See 45 CFR 164.524(c)(3)(ii).
minimum PHI necessary to meet the purpose of the use, disclosure, or request. This standard has an exception for disclosures to, or requests by, a health care provider for treatment purposes. For example, disclosure of PHI by a hospital to an inpatient rehabilitation facility is not subject to the minimum necessary standard.

OCR proposes to expand the minimum necessary standard to include an express exception for disclosures to, or requests by, a health plan or covered health care provider for care coordination and case management. This exception would only apply to care coordination and case management activities at the individual level. OCR provides the example of a health plan requesting disclosure to facilitate an individual’s participation in the plan’s new wellness program. The proposed exception would relieve the health plan from having to determine the minimum necessary amount of PHI for the purpose.

The minimum necessary standard is an important privacy protection. However, this standard must not stand in the way of information sharing between health care providers attempting to coordinate care with other providers. In providing an exception to the “minimum necessary” standard for disclosures for individual-level care coordination and case management, we believe covered entities will continue to request only the information needed and abide by existing rules regarding how PHI is used. We do not believe requests will become voluminous and overwhelm capacity. Rather, the proposed exception will facilitate sharing of individual-level information, improve care coordination, and enable the provision of value-based care.

OCR should finalize its exception to the “minimum necessary” standard for disclosures for individual-level care coordination and case management.

6. OCR should add an express permission for a covered entity to disclose PHI for individual-level care coordination and case management to a social services agency, community-based organization, or other similar third party.

Members of America’s Essential Hospitals understand the importance of non–health care social services in achieving effective care transitions and improved outcomes, including reduced readmissions. Many essential hospitals screen patients for food insecurity, housing instability, and other social determinants of health and refer these patients to community resources to help meet their social needs. For example, an essential hospital in Missouri developed a care transition program that reduced hospital admissions, emergency department (ED) visits, and costs. This hospital identified the need for a multidisciplinary team, bringing together licensed clinical social workers, client-community liaisons, and advanced-practice registered nurses, among other staff, to address both the clinical and social issues affecting their patient population. However, developing partnerships and ensuring necessary information flows freely across the spectrum of health and social services still poses challenges.

Some individuals—those experiencing homelessness or suffering from chronic conditions, including behavioral health and mental illness—receive care from a variety of sources, including HIPAA-covered entities, social services agencies, and community-based support programs. America’s Essential Hospitals supports efforts to remove barriers that might limit or discourage care coordination or case management, as well as those that impose regulatory burdens for providers working to connect patients to resources that will improve outcomes. We applaud OCR for recognizing that covered entities might be uncertain about the scope of the permission to disclose to these types of entities (social services, community-based organizations) for fear that they will inadvertently violate the HIPAA privacy rule, as these types of entities are not currently listed as permissible recipients of PHI.

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5 See 45 CFR 164.502(b)(1).
6 See 45 CFR 164.502(b)(2)(i).
OCR proposes to add an express permission for a covered entity to disclose PHI for care coordination and case management to a social services agency, community-based organization, or other similar third party. OCR further proposes to limit the scope of this permission to disclosures by covered entities for care coordination and case management for individuals, rather than population-based activities. **We support this express permission, for individual-level treatment, as a modification to the HIPAA privacy rule that will help eliminate confusion about a covered entity’s ability to disclose PHI to social services.** We encourage OCR to educate stakeholders about the scope of this express permission; particularly, the provision in which third parties receiving information do not have to be a health care provider (e.g., food or housing services). The agency also should facilitate and encourage greater wraparound support and more targeted care for vulnerable populations. Additionally, we recognize there might be instances in which some level of authorization from the patient would be appropriate (e.g., sensitive information) and encourage OCR to allow covered entities the flexibility to exercise their judgment when seeking such authorization.

7. **OCR should issue rulemaking implementing requirements related to 42 CFR Part 2, to ensure alignment with HIPAA and to facilitate related health information exchange.**

Essential hospitals deploy innovative approaches to treat patients with opioid and substance use disorder (SUD), but they continue to face operational challenges. When patients visit doctors and hospitals, most assume providers have a complete medical history and an awareness of addictions or substance use to factor into treatment and prescribing. However, requirements imposed by 42 CFR Part 2 (Part 2) limit providers’ use of patient substance use records for certain substance use treatment programs. Part 2—federal regulations that govern confidentiality of drug and alcohol treatment and prevention records—sets requirements limiting the use and disclosure of patients’ substance use records from certain substance use programs. Patients are required to give multiple consents, creating a barrier to whole-person, integrated approaches to care. A lack of access to the full scope of medical information for each patient can hinder the ability of providers and organizations to deliver safe, high-quality treatment and care coordination.

The modernization of privacy regulations and medical records for people with SUD is a critical component of responding to the opioid crisis and will improve the overall coordination of care in the nation. Part 2 must better align with HIPAA so health care providers can ensure comprehensive, coordinated substance use treatment and care. We appreciate the incremental changes OCR proposes to the HIPAA privacy rule that will facilitate the sharing of information related to SUD and serious mental illness (SMI). However, as OCR acknowledges in the rule, there is pending rulemaking to implement Coronavirus Aid, Relief, and Economic Security (CARES) Act requirements aligning Part 2 with the HIPAA privacy rule; these pending rules will allow providers to share information to address SUD and SMI.

Specifically, Part 2 should align with HIPAA for the purposes of treatment, payment, and health care operations. There are substantial barriers to the exchange of information on patients with SUD; these barriers are not limited to information specifically covered by Part 2. When a patient’s medical record contains information covered by both HIPAA and Part 2, this also creates a barrier to the exchange of information unrelated to SUD. Even if a provider needs to exchange information in the medical record unrelated to the disorder, the provider will have to carve out the Part 2 data, which are not always feasible given current limitations within EHR systems.

This past summer, the Substance Abuse and Mental Health Services Administration released a final regulation under the CARES Act, revising Part 2 regulations to facilitate quality improvement and claims management. OCR has also published informational materials and fact sheets on its website, clarifying how Part 2 relates to the exchange of information between providers. However, these steps do not go far enough to mitigate provider concerns. **We urge**
OCR to expeditiously issue its final rule to provide more direction to providers on the sharing of information under HIPAA and Part 2. Without harmonizing the varying requirements, it will be challenging, if not impossible, to know whether responding to a specific request is, in fact, allowed by applicable law.

8. OCR should ensure comprehensive, coordinated substance use treatment and care, while maintaining patient privacy and trust.

OCR proposes to amend certain provisions of the privacy rule, to encourage disclosures of PHI when needed to help individuals experiencing SUD, SMI, and in emergency circumstances. Specifically, OCR seeks to expand the ability of family and caregivers to help people experiencing SUD and SMI.

America’s Essential Hospitals recognizes the complexity and importance of addressing behavioral health issues, particularly as they relate to improving care for our nation’s underrepresented patients. Essential hospitals work to meet the behavioral and mental health needs of their patients by expanding behavioral health services within community health centers, as well as offering “curbside consultations” through which primary care providers can obtain an informal consultation from a psychiatrist.

As the health community, along with policymakers, builds out an addiction treatment infrastructure, it must integrate SUD, mental health, and primary care services to produce the best patient outcomes and establish the most effective approach to caring for people with complex health care needs. In proposing modifications to the HIPAA privacy rule, we urge OCR to avoid any chilling effect that might result from an erosion of trust by an individual in their health care team.

a. OCR should allow “good faith belief” to be the standard by which covered entities are permitted to make certain uses and disclosures in the best interest of individuals.

OCR proposes several modifications to HIPAA to encourage covered entities to use and disclose PHI more broadly in scenarios that involve SUD, SMI, and emergencies. The proposal to replace professional judgment with a “good faith belief” standard seeks to expand the ability of covered entities to disclose PHI to family members and other caregivers when they believe it is in the best interests of the individual, without fear of violating HIPAA. As noted by OCR, the existing professional judgment standard “presupposes that a decision is made by a health care professional, such as a licensed practitioner.” Whereas, good faith may be exercised by other workforce members, trained on their organization’s HIPAA policies, acting within the scope of their authority. We agree that a “good faith belief” standard could reduce hesitation by appropriate nonphysician health care personnel to disclose PHI when in the patient’s interest, thus better supporting the overall treatment plan for SUD and SMI.

However, the example provided by OCR for when and by whom a “good faith” belief standard might be exercised raises concern about unintended consequences:

“...front desk staff at a physician’s office who have regularly seen a family member or other caregiver accompany an adult patient to appointments could disclose information about upcoming appointments when the patient is not present, based on the staff’s knowledge of the person’s involvement and a ‘good faith’ belief about the patient’s best interests.”

It is critical that, if finalized, the change to “good faith” belief does not discourage patients from seeking needed health care services out of fear that their personal information might be given to those not directly involved in their care. As such, we encourage OCR to provide subregulatory guidance to promote understanding of the definition of “good faith
belief” and to supply clear examples of permitted and prohibited activities for those covered entities treating patients with SUD and SMI.

b. OCR should adopt a “reasonably foreseeable threat” standard for use and disclosure of PHI while ensuring privacy protections remain for those impacted by SUD and SMI.

OCR proposes changes to the HIPAA privacy rule that enable covered entities to prevent and lessen harm to individuals or the public. When addressing threats of harm, OCR proposes to replace the “serious and imminent threat” standard with a “serious and reasonably foreseeable threat” standard. For example, under this broader standard, a health care provider could promptly notify a family member that an individual is at risk of suicide, even if the provider cannot predict that a suicide attempt is likely to occur imminently.

We support the goal of promoting parental and caregiver involvement in the treatment of loved ones impacted by SUD and SMI. When evaluating proposals that expand permissions on use and disclosure of PHI, it is important to balance the benefit of involving certain caregivers and family with the risk of interference with individuals’ ability to direct and manage their own care or to avoid care altogether.

OCR notes the purpose of this proposed change in standard is to improve the timeliness of disclosures that might be delayed due to uncertainty regarding whether a threatened harm is “imminent.” We agree that a “reasonably foreseeable” standard would be easier to apply than imminence and is the best approach moving forward, though we caution that overly broad regulatory language could create ambiguity and result in unintended consequences for providers in applying this standard.

Additionally, we know that a contributing factor to the current opioid epidemic is stigma, and stigma has an impact on clinical outcomes and public policy. For example, assuming a person with a diagnosis of mental illness or an individual lacking social support is a threat to themselves or others merely because of their diagnosis or social risk factor is stigma. We appreciate OCR’s acknowledgment that disclosures based on such implicit bias or unwarranted assumptions are inappropriate.

9. OCR should provide increased public outreach and education on existing provisions of HIPAA and ensure comprehension by providers and patients—in particular, those with LEP.

America’s Essential Hospitals and its members continually advance work to improve cultural competency, increase health literacy, and provide communication and language assistance. By involving patients as active participants in their care, hospitals can better help them identify care choices, as well as respond to clinical and social needs that might improve health outcomes.

In many cases, patients are unaware of permitted use and disclosures of PHI for care coordination or case management. For example, health care providers who believe disclosures to certain social service entities are necessary for, or might assist, the individual’s health or mental health care are permitted to disclose the minimum necessary PHI to such entities

without the individual’s authorization. It is important that patients are made aware of, through plain language educational materials, their right to access their medical record and to limit who has access to their PHI. **We encourage OCR to increase its outreach and education on the existing privacy rights of individuals and the specific instances in which providers are authorized to disclose PHI for treatment purposes.**

Further, OCR should develop updated materials for providers that illustrate, in real-world scenarios, when they are permitted to disclose PHI for treatment purposes. In doing so, providers are better able to effectively conduct care coordination activities that promote overall health and well-being. For example, case studies could illustrate the points along the care continuum—from inpatient to post-discharge, community-based care—when PHI might be disclosed, to what extent the minimum necessary standard would apply, and required authorizations related to disclosure.

Additionally, individuals with LEP require appropriate language assistance or auxiliary aids and services to fully participate in their care plan, including notice of privacy given to the patient. While people with LEP account for about 8 percent of the U.S. population overall, they represent more than 20 percent of the uninsured population and 12 percent of the Medicaid population. Language barriers jeopardize the health of many LEP individuals by reducing access to care and hindering communication with providers. Members of America’s Essential Hospitals work daily to improve care quality through programs to break down language barriers and engage patients and families to improve the care experience. A patient’s ability to read and understand a notice of privacy practices has an impact on patient safety and the likelihood of a patient seeking care. **We urge OCR to provide outreach in a manner that ensures all patients understand their rights regarding PHI, with particular attention to LEP patients and those with low health literacy.**

10. OCR should eliminate the requirement for covered health care providers to make a good faith effort to obtain written acknowledgement of receipt of a Notice of Privacy Practices (NPP).

America’s Essential Hospitals agrees with OCR’s assessment that the signature and recordkeeping requirements associated with NPPs impose undue burden for essential hospitals and create a barrier to efficiency in care delivery. Technology advances allow the NPP to be readily available online for patients and accessible to individuals. The current requirement of written receipt unnecessarily delays care, treatment, and other health care services provided directly to the patient. Further, the document itself does little to promote better understanding and awareness of patients’ rights under HIPAA. **We urge OCR to eliminate the requirement to obtain written acknowledgement of receipt of an NPP.**

11. OCR should not enforce any new and revised standards until at least one year after the effective date of the final rule.

The effective date of a final rule would be 60 days after its publication. OCR proposes covered entities and their business associates would have until the “compliance date”—180 days after the effective date of the final rule—to establish policies and practices to achieve compliance with new or modified standards.

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Covered entities will need more time to develop patient education, modify internal operations, and create policies, in particular those related to new rights to access and providing PHI to third parties. **We urge OCR to give covered entities at least one year after the effective date of the final rule to come into compliance before taking enforcement action.**

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America’s Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Senior Director of Policy Erin O’Malley at 202-585-0127 or eomalley@essentialhospitals.org.

Sincerely,

Bruce Siegel, MD, MPH
President and CEO