



AMERICAN  
PSYCHOLOGICAL  
ASSOCIATION

May 6, 2021

US Department of Health & Human Services  
Office for Civil Rights  
Hubert H. Humphrey Building, Room 509F  
200 Independence Avenue SW  
Washington DC 20201

Re: ***Proposed Modifications to the HIPAA Privacy Rule to Support and Remove Barriers to Coordinated Care and Individual Engagement NPRM (RIN 0945-AA00)***

The American Psychological Association (APA)<sup>1</sup> appreciates the opportunity to comment on the proposed modifications to the HIPAA Privacy Rule Notice of Proposed Rulemaking (NPRM), which seeks to enhance patient access to their protected health information (PHI) and to improve coordination of care.

We offer comments about the following provisions in the proposed rule in the order as they are addressed in the NPRM. Bold text indicates the proposals that cause us the greatest concern, as briefly explained:

1. **Adding an exception to the “minimum necessary” rule for care coordination and case management activities for health plans.** We oppose this because the NPRM provides no cogent justification for this enormous invasion of patient privacy.
2. Adding care coordination and case management activities with social services organizations and home and community-based service providers to the “payment” and “health care operations” definitions.
3. Amending the patient’s right of access to his/her personal health information (PHI) to **allow patients to immediately inspect their records when they are in-person for services.** Because of the substantial difficulties and burdens it would pose for psychological practices, particularly small ones, we urge an exception for such practices.
4. Shortening the timeframe in which a covered entity is required to respond to a patient’s access request.
5. Changing the content of the Notice of Privacy Practices and how that information is disseminated to patients.

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<sup>1</sup> APA is the professional organization representing more than 122,000 members and associates engaged in the practice, research and teaching of psychology. APA works to advance psychology as a science and profession to benefit society and improve lives.

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We focus on how these proposed changes may impact psychologists and their patients, noting that mental health records are typically subject to a higher level of protection from disclosure given the often sensitive nature of the information involved. We have concerns that while the goal is to ensure patients have access to their PHI and more coordinated care, these proposed revisions may have unintended negative consequences for patients.

In general, APA favors improving patients' access to their PHI so they can be better informed about their health care and be more involved in care decisions. We oppose certain proposals, however, where they create unique burdens for psychological practices, especially for small psychological practices. In contrast to most of the health care provider world, psychological services are largely still delivered in standalone practices. Thus, a large portion of psychologists work in small practices with limited or no support staff. Many of the proposed changes would disproportionately affect these small practices. We propose that small psychological practices be exempted from several of the provisions noted below. For simplicity, we propose using the same small employer definition (50 or fewer employees) as used in [MHPAEA](#).

In addition, for the near future, psychologists (and other mental health professionals) will need to focus their energies on the "mental health tsunami" created by the pandemic, which we expect to continue for years after the COVID pandemic ends.<sup>2</sup> This comes on top of other recent changes that have strained the capacity of smaller practices with limited or no compliance resources: pivoting suddenly to telehealth 14 months ago; now shifting back partially to in-person services; and complying with the newly instituted Information Blocking Rule which does not align easily with HIPAA. We urge that psychological practices, particularly small and solo practices, be allowed to focus on their dramatically increased patient caseload, rather than the burden of adapting to and complying with more onerous Privacy Rule requirements.

## **1. Patient's access rights**

### **A. Immediate Patient Access While Onsite to Obtain Services**

One of our other major concerns, particularly for smaller psychological practices, is the proposal that patients be allowed immediate access to inspect their records (that are readily available at the point of care) while they are in the office for an appointment.

For a small psychology practice, this would typically mean that at the end of a session, a patient would ask to see his/her record. Such a request would create multiple problems: 1) Psychologists typically have someone sit with a patient when the patient is reviewing records. Some patients create the concern that they might alter or remove parts of the record.<sup>3</sup> For small practices with little or no support staff, there might be no one available to do this if the psychologist is about to start the next appointment. 2) Most psychologists review the record before giving patient access in order to: a) assess information that may be upsetting to the patient, which the psychologist would

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<sup>2</sup> See APA's latest [Stress in America survey](#).

<sup>3</sup> This is a concern with some psychology patients. Members have reported patients stealing the record. Motivations for altering or removing parts of the record include not wanting to have certain diagnoses or sensitive information -- e.g., suicidality, drug or alcohol use -- in their record if that record must be released for security clearances, applications for sensitive jobs or for life insurance.

normally discuss with the patient in advance; and b) check the patient's record for materials requiring redaction and/or special handling -- e.g., psychological test answers commingled with test questions subject to copyright protection<sup>4</sup>, addiction treatment information protected under 42 CFR Part 2, multiple patient issues, information obtained from family members under a promise of confidentiality, and minor proxy issues.<sup>5</sup>

While APA recognizes the importance of improved patient access, we urge that this provision be subject to an exception for psychological practices, or at least small psychological practices (as noted in the Introduction), for the reasons outlined above.

## **B. Shortening the time frame for responding to patient requests for access**

We also request a small psychological practice exemption from the proposed shortening of the time frame from 30 to 15 days for responding to patient access requests, because small practices with limited support staff may have difficulty responding to such requests within such a dramatically shortened time period.

## **2. "Care coordination and case management" activities**

### **A. Exception to the Minimum Necessary Standard for Care Coordination and Case Management by Plans**

One of our biggest objections is to what we consider a major and unjustified privacy giveaway to health insurance plans by the last Administration: the proposed exception to the minimum necessary doctrine for care coordination and case management (CC/CM) activities by health plans.<sup>6</sup>

Currently, there are only six exceptions to this fundamental HIPAA precept. Excluding the three that relate to complying with HIPAA and other laws, there are just three exceptions for uses and disclosures among covered entities and patients: 1) disclosures to or requests by a health care provider for treatment; 2) use by or disclosure to the individual; and 3) uses or disclosures pursuant

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<sup>4</sup> When psychologists have a patient's completed psychological and neuropsychological tests in the record, the patients' responses, which are PHI, are often on the same paper as the test publishers' copyrighted test questions. This requires the psychologist to redact the copyrighted test material before giving the patient access to the record, based on guidance from the publishers.

<sup>5</sup> Some of these same issues may arise under the Information Blocking regulations that went into effect on April 5, 2021, which give patients immediate access to their EHI in a certified EHR. But this proposed change to Section 524 would impose these problems on the large percentage of psychologists whose records are not subject to immediate patient access because they have paper records or non-certified EHRs. (This high percentage is attributable to the fact that psychologists were not eligible for funding for EHRs as "meaningful users" under the HITECH Act.)

<sup>6</sup> We are not convinced that this exception is necessary for CC/CM disclosures to other covered health care providers, but we are significantly less opposed to that proposed change to the minimum necessary exception. The reasons are: a) the research cited in the NPRM does demonstrate, and APA recognizes, the importance of CC/CM activities between providers; b) if there were a scenario of overbroad record requests (like those described below), we have greater confidence that another provider would honor a psychologist's determination that parts of the record had no relevance to current care issues; and c) this proposed exception does not go far beyond the existing Minimum Necessary exception relating to treatment by providers.

to an authorization. These three exceptions all have obvious and clear justifications;<sup>7</sup> The same cannot be said for the proposed exception for disclosures to plans regarding CC/CM activities.

Over half of the respondents to the 2019 Request For Information opposed any further exceptions to the minimum necessary standard, noting concerns about erosion of patient privacy and other patient harm (NPRM at 86 Fed. Reg. 6474) – we agree.

Potential privacy impacts. While the example listed in the NPRM seems innocuous (a health plan coordinating care for a mental health referral), nothing in the proposed exception would prevent plans from making a broad request under the claim of care coordination and case management activities, but then using information obtained under those auspices against the patient to deny care. Even if the plan did not use that information against the patient, this exception would create an extremely unnecessary imposition on patients' privacy.

Consider the example of a patient who sees his/her psychologist for many years for depression and marital problems and pays for that care out-of-pocket. Years later, a traumatic event causes an unrelated mental health crisis necessitating a brief hospitalization for PTSD, for which the patient seeks coverage by the health plan. Under the proposed new exception, the plan could tell the psychologist that it needs the patient's entire record over the years for CC/CM purposes. Even if the psychologist had a strong professional opinion that the years of prior records were irrelevant to the new crisis, the psychologist would have no grounds under HIPAA to protect the patient's privacy and denying the overly broad request.

The proposed exception could even be used to inappropriately obtain mental health records when a patient seeks treatment for a physical health issue. For example, if a patient is experiencing chronic pain after a car accident, the plan could request mental health records that contain sensitive yet irrelevant information, based on an unjustified suspicion that such treatment might be connected to the patient's chronic pain.

Lack of justification. The NPRM does not offer any clear or compelling public policy arguments justify this invasion of patient privacy by plans.

First, the NPRM makes no claim that health plans' CC/CM activities have been hampered by the minimum necessary standard. If the current system is working, it should not be changed to the detriment of patients privacy.

Second, while the NPRM has an extensive discussion about the importance of CC/CM activities, virtually all of the discussion focuses on provider-to-provider or provider-patient coordination.<sup>8</sup> There appear to be no studies cited in the NPRM noting the importance of CC/CM activities by health plans.

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<sup>7</sup> Disclosures to or requests by a health care provider for treatment recognize the importance of providers having the full information necessary to make critical treatment decisions, as well as providers' typical ethical obligations to protect the privacy of PHI entrusted to them and act in the best interest of patients. The exception regarding disclosures to and use by individuals makes sense because there is no need to protect the privacy of PHI from the individual himself or herself. The exception for authorizations makes sense because an authorization defines exactly what PHI is to be released.

<sup>8</sup> NPRM at 86 Fed. Reg. 6448-50.

Third, the NPRM seems to use provider confusion about how to comply with the minimum necessary standard for CC/CM activities as a justification for this exception. We have several problems with this justification:

- a) Our large membership of providers does not seem to find this minimum necessary application to be particularly confusing; out of thousands of Privacy Rule questions we've received over the years, confusion about this issue almost never arises.
- b) The NPRM provides no explanation of why providers would find this particular provision more confusing than the many other aspects of the Privacy Rule that are challenging and confusing to comply with.
- c) Even if there is some confusion among providers about how to comply with the minimum necessary standard in certain situations, any such confusion does not justify eroding patient privacy protections.
- d) If this confusion is really a major concern, additional guidance from OCR would be a better solution than sacrificing patient privacy protections.

**B. Including CC/CM disclosures to social service and community organizations within the "Treatment" and "Payment" definitions**

This proposed revision would also permit disclosures of PHI to certain third parties for individual-specific case management and care coordination activities, such as social services organizations, community-based organizations and home and community-based service providers, by including these activities within the definitions of "treatment" or "health care operations." Expanding the parameters to whom PHI may be disclosed without additional patient authorization could result in that information losing ongoing HIPAA protections. The various third parties may not qualify as a "covered entity" under HIPAA. In most cases, these third parties would not likely be considered business associates requiring business associate agreements to ensure HIPAA privacy protections. Therefore, there would be no guarantee that a patient's PHI would continue to be protected once disclosed to social service agencies or other similar third parties.

We are concerned that privacy protections for sensitive patient information would be sacrificed for the sake of improving health care integration and coordination activities. The goals ought not to be mutually exclusive. Moreover, patients would not necessarily be aware that their PHI would lose protections once disclosed to any of these third parties involved in care coordination or case management functions.

If these third parties are not subject to HIPAA as either a covered entity or business associate, then it is critical that patients (or their legal representatives) be notified in advance that their health data may no longer be covered by HIPAA. In addition, these third parties ought to be required to attest in writing that they abide by HIPAA Privacy Rule mandates and limit any further uses or disclosures of patients' PHI received in furtherance of care coordination or case management – absent additional patient consent or authorization.

There is also a health equity issue to consider given that patients of lower socioeconomic status are more likely to utilize social service and community-based services agencies. If these agencies are not bound to maintain privacy protections for these patients' health data, then patients lacking

resources would be unfairly penalized creating a two-tier system of patient data privacy. This clearly runs counter to the intent of HIPAA.

### **3. *Notice of Privacy Practices requirements***

The proposed rule seeks to make some significant changes to the requisite Notice of Privacy Practices (Notice) that covered entities must provide to patients. First, covered entities would no longer be required to obtain an acknowledgment of receipt of the Notice from the patient. In lieu of providing each patient with a paper copy of the Notice for signature to acknowledge having read and understood the policy, it appears that covered entities would now be allowed post the Notice for patients to review either in-person or electronically.

Second, the proposed rule would amend the information that must be included in the Notice, requiring additional information about how to access one's PHI or to direct such information to a designated third party; how to file a HIPAA complaint; and the patient's right to receive a copy of the Notice and to discuss the contents with a person designated by the covered entity.

APA supports lessening paperwork or administrative burdens on providers so long as it is not at the expense of patients' best interests. This is especially true for psychologists who often work in solo or very small group practices. The reality is that patients are often required to sign forms whether it be new patient forms or required renewals without necessarily reading all of the forms closely. Therefore, it would not adversely affect patients' best interests by allowing the Notice to be posted rather than providing hard copies to patients. It would be much simpler for the psychologist to post the Notice either where it would be easily and conspicuously displayed in the practice setting and/or the practice's website, if available.

However, it would be helpful for OCR to provide some examples of sufficient, appropriate notification of privacy practices in lieu of the current practice of providing paper copies. This could assist providers in ensuring that their efforts to advise patients of their rights are sufficient and align with HHS's intent.

Finally, we request that psychological practices, at least small ones, be given an exception allowing them to comply with the new Notice requirements simply by providing an addendum to the prior Notice. This will have three benefits. First, our members report that their patients rarely read Notices. We believe that a shorter addendum focusing on what is new would be more likely to catch their attention, and make it easier for psychologists to focus on the new provisions in talking with patients. Second, it will be less of an administrative burden for small practices to develop a brief Notice addendum. Third, it be easier for APA to provide support to members in the form of a template addendum, as opposed to providing inserts that would have to be electronically copied and pasted into the variety of Notices that our members are currently using.

If our addendum suggestion is adopted, it would be helpful for OCR to develop a sample Notice addendum, as it has previously done for the entire Notice. That kind of sample language is very helpful for providers and provider organizations trying to ensure compliance.

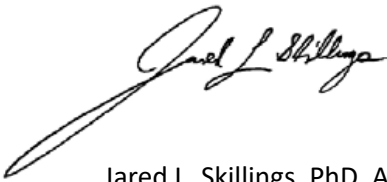
### **Conclusion**

We encourage HHS and more specifically, the Office of Civil Rights, as well as other policymakers to carefully consider the potential impact of some of these proposed changes on patient privacy as well

as individual clinicians practicing in solo and very small group practices. The potential impact on mental health care providers is particularly critical given what sensitive patient information is at stake and the heavy demands placed on mental health professionals after the pandemic.

Thank you for the opportunity to offer our comments on this proposed rule. We look forward to your responses. If APA can be of any further assistance, please feel free to contact Alan Nessman ([ANesman@apa.org](mailto:ANesman@apa.org)) and Deborah Baker ([DBaker@apa.org](mailto:DBaker@apa.org)).

Sincerely,

A handwritten signature in black ink, reading "Jared L. Skillings". The signature is fluid and cursive, with a long, sweeping underline that extends to the left.

Jared L. Skillings, PhD, ABPP  
Chief of Professional Practice  
American Psychological Association