National Association for Behavioral Healthcare

Access. Care. Recovery.

6 May 2021

Office of Civil Rights
US. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Comments on Proposed Modifications to the HIPAA Privacy Rule to Support, and Remove Barriers to, Coordinated Care and Individual Engagement [RIN 0945-AA00]

The National Association for Behavioral Healthcare (NABH) respectfully submits the following comments on the Notice of Proposed Rulemaking on "Proposed Modifications to the HIPAA Privacy Rule to Support, and Remove Barriers to, Coordinated Care and Individual Engagement." NABH represents behavioral healthcare systems that provide mental health and addiction treatment across the entire continuum of care, including inpatient, residential treatment, partial hospitalization, and intensive outpatient programs, as well as other facility-based outpatient programs including medication assisted treatment centers. Our membership includes behavioral healthcare providers across the United States in almost every state.

Protecting the privacy of information regarding the receipt of behavioral healthcare is a critical concern for our members due to the sensitivity of medical records regarding mental health and addiction treatment, the vulnerable condition many individuals with these conditions may experience, and the stigma that still surrounds accessing behavioral healthcare. Nonetheless, updating information-sharing restrictions that impede care coordination and supporting greater collaboration among behavioral healthcare providers, patients' family members, and other individuals who are important to patients is long overdue.

Moreover, it is important to consider these issues in the context of greatly increased drug overdoses and elevated levels of anxiety and depression and suicidal ideation, especially among children and adolescents during the Covid-19 pandemic.[1, 2, 3] Alarming trends regarding drug overdoses and suicides were already evident for years before this most recent public health crisis. Serious behavioral health conditions had become so prevalent and elevated, they were driving down overall life expectancy in the United States.[4]

We expect the Covid-19 pandemic to cause a lingering increased need for behavioral healthcare. Large-scale disasters such as the current pandemic are known to have widespread and long-lasting detrimental effects on mental health and substance use.[i] Moreover, studies of past disasters have shown the mental health distress and suicidality often do not peak until years after the disaster has ended.[ii]

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[1] Vahratian A, Blumberg SJ, Terlizzi EP, Schiller JS. Symptoms of Anxiety or Depressive Disorder and Use of Mental Health Care Among Adults During the COVID-19 Pandemic — United States, August 2020–February 2021. MMWR Morb Mortal Wkly Rep. ePub: 26 March 2021. DOI: http://dx.doi.org/10.15585/mmwr.mm7013e2.

[2] Czeisler MÉ , Lane RI, Petrosky E, et al. Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1049–1057. DOI: http://dx.doi.org/10.15585/mmwr.mm6932a1external.

[3] Ahmad FB, Rossen LM, Sutton P. Provisional drug overdose death counts. National Center for Health Statistics. 2021. DOI: https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm.

[4] Bastian B, Tejada Vera B, Arias E, et al. Mortality trends in the United States, 1900–2018. National Center for Health Statistics. 2020. DOI: https://www.cdc.gov/nchs/data-visualization/mortality-trends/index.htm.

Overlap Among *Health Insurance Portability and Accountability Act*, Interoperability, and 42 CFR Part 2 Regulations

We urge the Department of Health and Human Services (HHS) to anticipate and account for interactions between the proposed changes to the privacy rules under the *Health Insurance Portability and Accountability Act* (HIPAA) issued by the Office of Civil Rights (OCR), the interoperability and information blocking rules recently issued by the Office of the National Coordinator for Health Information Technology (ONC), and the current rules and future changes regarding 42 CFR Part 2 under the purview of the Substance Abuse and Mental Health Services Administration (SAMHSA). All three sets of rules must be coordinated carefully to minimize administrative burden and avoid inconsistency and confusion that would undermine the goal of improving care coordination and patient engagement in treatment. All three sets of regulations have unique implications for behavioral healthcare, and we urge you to consider the impact these varied sets of rules will have specifically on mental health and addiction treatment providers as you finalize any changes to these HIPAA rules. Before these rules become effective, we also urge you to develop sub-regulatory guidance regarding how these three sets of requirements interact and affect the disclosure of information regarding mental health and addiction treatment specifically.

Modifications to the Right to Inspect and Obtain Copies of Protected Health Information

Improving access to treatment information can improve care coordination and encourage engagement by individuals in their own recovery from mental illness and addiction. As noted in the NPRM, improvements in care coordination and patient engagement are critical to supporting reforms in our healthcare system to support value-based care. However, we have concerns about some of the proposed changes.

We urge OCR to consider the implications of giving patients the right to immediately inspect their protected health information (PHI) and also photograph and/or video record their medical records at the point of care. Such a broad right of access puts at risk the privacy rights of other patients in those settings. In addition, this expanded right of access would impose unreasonable burdens on providers who would have to hire more staff to be able to respond to such requests on the spot and would very likely disrupt care for other patients. Providers should have discretion to determine when and where medical records can be shared and photographed to prevent disruptions in care and violations of the privacy of other patients.

The proposed changes to the rules governing patients' access to their PHI should at least be postponed until the technology is widely available to support compliance with these new access and disclosure rules. The ONC interoperability rules establish new requirements for certified health information technology vendors to facilitate access to health information electronically; however, those requirements are not in effect until December 31, 2022. We urge OCR to delay the effective date for these proposed changes to the right of access rules under HIPAA until after the technology necessary for responding to these patient requests is available and providers have had time to implement it.

The proposal to shorten the timeframe for responding to patients' requests for copies of or access to their medical records from 15 to 30 days may seem reasonable for providers who have robust health information technology systems (HIT) and electronic health records (EHRs). However, behavioral healthcare providers are far less likely than other types of healthcare providers to have EHRs or similar technology to facilitate responding to requests for sensitive PHI. This lag in adoption of HIT results from psychiatric hospitals and other behavioral healthcare providers being excluded from the subsidies provided under the *Health Information Technology for Economic and Clinical Health Act* (HITECH) to other healthcare providers to help them purchase and implement HIT. We urge OCR to make an exception to any shortened timeframe and provide the full 30-day response time for behavioral healthcare providers until they are provided comparable support for implementation of HIT that the HITECH Act program offered to other healthcare providers.

Information Disclosure to Third Parties

We are also concerned about the proposal in this NPRM that allows patients to direct healthcare providers to disclose their PHI to third parties with verbal requests instead of maintaining the requirement that these requests be in writing. It would be unreasonable to expect healthcare providers to track verbal requests and undoubtedly risk unauthorized release of PHI by accident. We support limiting this disclosure requirement to information included in EHRs to minimize the burden of these requests. Moreover, we urge OCR to clarify that providers would not be responsible for the use of PHI disclosed to third parties at the patient's request.

The proposal to require providers to submit requests on behalf of patients to their other providers for the patient's PHI also raises serious concerns. Requiring providers to make these requests on behalf of patients is likely to cause confusion and delay access to the information because it is unclear if or how the other provider will know if the patient requested that their information be shared. The interoperability rules also address sharing of information. It is unclear how allowing providers to request PHI at the request of their patients affects implementation of the ONC rules on interoperability. Again, we urge OCR to clarify how these separate sets of regulations interact and how providers are to navigate these complex sets of rules.

Care Coordination and Case Management

NABH supports the proposal to include individual-focused care coordination and case management in the definition of "health care operations." Individuals with behavioral health conditions often have co-morbid physical health conditions as well as co-occurring mental health and addiction issues. The ability to share information more easily among providers and programs that address these varied needs will improve care for individuals with behavioral health conditions. Improved coordination with providers of services to address social determinants of health is also critically important for improving outcomes for individuals with serious behavioral health conditions. For these reasons, we also support the clarification in this NPRM that PHI may be disclosed to social services agencies, community-based organizations, and home and community-based service providers in support of care coordination and case management to address the health-related needs of individuals.

Standards for Disclosing Information When in an Individual's Interest or to Prevent Harm

The proposal in this NPRM to authorize disclosure of PHI based on a "good faith belief" that it would be in the best interests of the individual instead of requiring that the assessment be based on "professional judgement" is a helpful clarification. This proposed change would decouple the determination of when disclosure of information would be helpful from the professional credentials of the person in a position to share information with family members or others. Professional clinicians are often not available in the urgent circumstances when questions about disclosure of information may arise as they have other roles to fill in treatment settings besides information management. Moreover, non-clinician staff in healthcare settings may have a stronger sense of what would be in the best interest of individuals receiving care in those settings. These principles apply regarding disclosure of information for individuals with serious mental illness or substance use disorder as well as individuals with other serious conditions.

We also support the proposal to change the standard for disclosure of PHI to prevent harm from "serious and imminent threat" to "serious and reasonably foreseeable threat." This proposed new standard for disclosing information to prevent harm would seem to allow healthcare providers more latitude to anticipate a dangerous situation instead of having to wait until an emergency arises. This approach seems far more helpful for preventing threats to the safety of the individual who is the subject of the PHI or others.

OCR should develop sub-regulatory guidance to clarify the definition of "good faith belief" and "serious and reasonably foreseeable threat" and include additional examples and scenarios of when these conditions would be met regarding disclosure of PHI for individuals with serious mental illness or substance use disorders.

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Notices of Privacy Practices

NABH supports the proposal to eliminate the requirement that healthcare providers collect written acknowledgment from patients that they have received the provider's Notice of Privacy Practices (NPP). The existing written acknowledgement requirement has not resulted in improvements to patients' awareness or understanding of their privacy rights or providers' information sharing practices. Furthermore, if any of the proposed requirements regarding the content of the NPP is adopted, we urge OCR to develop a standard federal notice that providers could use with the assurance that their NPP complies with HIPAA. In addition, providers will need additional time to implement any changes to the NPP requirements.

Effective Date

As Covid-19 continues to have a significant impact on behavioral health, mental health and addiction treatment providers must remain focused on improving access to care. They continue to struggle with the new demands imposed by social distancing and precautions they must take to prevent Covid-19 infection. Healthcare staff and providers were already greatly strained by the ongoing stress and demands created by this pandemic. Moreover, behavioral healthcare providers and HIT vendors are still working to implement the new interoperability standards as they continue to face staffing shortages. Thus, we urge OCR to delay the deadline of this any additional regulatory changes such as those proposed in this NPRM. The proposed compliance deadline of eight months after publication does not provide adequate time for implementation of these changes even without the extenuating circumstances described above.

Thank you for considering our concerns and recommendations. If you have any questions, please contact me directly at shawn@nabh.org or 202-393-6700, ext. 100, or contact NABH Director of Policy and Regulatory Affairs, Kirsten Beronio at kirsten@nabh.org or 202-393-6700, ext. 115.

Sincerely,

Shawn Coughlin
President and CEO

About NABH

The National Association for Behavioral Healthcare (NABH) represents provider systems that treat children, adolescents, adults, and older adults with mental health and substance use disorders in inpatient behavioral healthcare hospitals and units, residential treatment facilities, partial hospitalization and intensive outpatient programs, medication assisted treatment centers, specialty outpatient behavioral healthcare programs, and recovery support services in nearly all 50 states. The association was founded in 1933.

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[i] Shultz JM, Perspectives on disaster public health and disaster behavioral health integration, Disaster Health Vol. 2, No. 2, pp. 69-74 Apr-Jun 2014 available online.

[ii] Luo F, Florence CS, Quispe-Agnoli M, et al, Impact of Business Cycles on US Suicide Rates, 2018-2007, Am J Public Health, Vol. 101, No. 6, pp. 1139-1146 June 2011 available online.