



February 12, 2019

Roger Severino
Director
Office for Civil Rights
U.S. Department of Health and Human Services
Attention: RFI, RIN 0945-AA00
Hubert H. Humphrey Building
Room 509F
200 Independence Avenue, SW
Washington, DC 20201

Dear Director Severino:

Thank you for the opportunity to provide feedback on the Office for Civil Rights' Request for Information (RFI) on Modifying HIPAA Rules to Improve Coordinated Care.

The American Health Information Management Association (AHIMA) is the national nonprofit association of health information management (HIM) professionals. Serving 52 affiliated component state associations including the District of Columbia and Puerto Rico, AHIMA represents over 103,000 health information management professionals dedicated to promoting and advocating for best practices and effective standards in health information. Whether serving as privacy or security officers, HIM department directors, or release of information specialists, AHIMA's credentialed and certified HIM professionals are committed to the appropriate use and disclosure of health information while ensuring that health information is accurate, timely, complete, and available to patients and clinicians.

Although the request for information discusses a variety of topics, we would like to offer some general comments below, followed by more specific responses to the questions posed in the RFI.

General Comments

Enhancing the Individual Right of Access Under HIPAA

The individual right of access under HIPAA is fundamental to improving health and healthcare. AHIMA continues to support efforts to not only clarify an individual's right to access their health information but enhance the ability to obtain such access while improving workflow for HIM professionals who are often tasked with fulfilling such requests.

Along these lines, AHIMA believes that opportunities exist to enhance an individual's right to access their health information with modifications to HIPAA and beyond. Ultimately, the best measure of whether an individual access request has been fulfilled is whether the needs of the requestor have been met. It is often the case that a patient may request "any and all records" because he or she may not know what information they are seeking. This may even include requests for information not contained in the designated record set. From a patient perspective, this frequently results in a paper or PDF-based

document that is indecipherable, unreadable, and not computable. Similarly, HIM professionals are often overwhelmed by such requests, as current record systems are vastly complex and involve complicated workflows as we transition from paper to electronic health record (EHR) systems.¹ In turn, HIM professionals frequently spend considerable time and resources assisting patients in clarifying and identifying the exact information the patient may need. However, not every covered entity has the HIM resources or medical record expertise to provide such assistance.

In collaboration with the American Medical Informatics Association (AMIA), AHIMA has developed the following recommendations that we believe will enhance the ability of individuals to access their protected health information (PHI) under HIPAA and reduce administrative burden for HIM professionals in fulfilling such requests.

(1) Converge HIPAA with health IT certification

- a. Establish a new term, “health data set,” which includes all clinical, biomedical, and claims data maintained by a covered entity or business associate. This health data set would support the HIPAA individual right of access and be supported by ONC’s Certification Program so individuals could view, download, or transmit to a third party this information electronically and access this information via application programming interfaces (API); or
- b. Revise the HIPAA “designated record set” (DRS) definition and require certified health information technology to provide the amended DRS to patients electronically while maintaining computability. This revision would provide greater clarity and predictability of what constitutes the designated record set to providers and patients.

(2) Extend the HIPAA right of access to Non-Covered Entities (NCEs)

- a. NCEs manage individual health data, such as mHealth and health social media applications. The goal is uniformity of health data access policy, regardless of covered entity, business associate, or other commercial status.

(3) Encourage note sharing with patients in real time

- a. Promote efforts such as OpenNotes through Medicare and Medicaid payment programs, such as the Merit-based Incentive Payment System.

(4) Clarify existing regulatory guidance on third-party access to patient data

- a. Especially related to third-party legal requests that seek information without appropriate patient-direction and beyond what is part of the designated record set.

Align 42 CFR Part 2 with HIPAA

As members of the Partnership to Amend 42 CFR Part 2, AHIMA is committed to aligning the 42 CFR Part 2 regulation with HIPAA for purposes of treatment, payment, and healthcare operations to allow appropriate access to patient information that is essential for providing whole-person care while protecting patient privacy. The Part 2 regulation currently presents operational challenges for HIM professionals working in designated Part 2 programs. HIM professionals working in such programs are

¹ X4 Health, “Requesting Health Records in the Modern Era,” Available at: <https://www.x4health.com/healthdata>.

often forced to work with paper records to ensure that a patient's Part 2 information is kept confidential. In instances where a Part 2 program may have an EHR, data segmentation functionality is often not available. Lacking such functionality, HIM professionals must keep a patient's addiction records separate from the rest of the patient's medical record—resulting in the creation of two separate medical records. Because such information is kept separate, providers are often unaware of the risks to their patient from multiple drug interactions and co-existing medical problems even though substance use disorders can have a cascading effect on an individual's health and must be carefully managed and coordinated.

We recognize that revisions to 42 CFR Part 2 are beyond the scope of OCR's regulatory authority. However, if OCR seeks to make changes to the HIPAA Rules to "remove regulatory obstacles and decrease regulatory burdens in order to facilitate efficient care coordination and/or case management and to promote the transformation to value-based healthcare, while preserving the privacy and security of PHI," any revisions to HIPAA should be accompanied by modernization of 42 CFR Part 2.² Along these lines, AHIMA recommends that HHS, through SAMHSA, institute a separate rulemaking process for modernization of 42 CFR Part 2 to ensure that it is harmonized with any subsequent revisions to the HIPAA Rules.

Promoting Information Sharing for Treatment and Care Coordination

- 1. How long does it take for covered entities to provide an individual with a copy of their PHI when requested pursuant to the individual's right of access at 45 CFR 164.524? How long does it take for covered entities to provide other covered entities copies of records that are not requested pursuant to the individual's right of access? Does the length of time vary based on whether records are maintained electronically or in another form (e.g., paper)? Does the length of time vary based on the type of covered entity? For instance, do some types of healthcare providers or plans take longer to respond to requests than others?**

The amount of time it takes a covered entity to provide an individual with a copy of their PHI when requested pursuant to 45 CFR 164.524 currently varies due to a number of factors.

In some states, covered entities are required to fulfill such requests in less than the 30 days required under HIPAA, which shortens the time by which a covered entity must fulfill an individual access request. Additionally, there may be variability under state law with respect to whether an extension for an access request is allowed and the allowable time for an extension, if permitted. For example, Washington state statute states, "if the information is in use or unusual circumstances have delayed handling the request, [a healthcare provider] must inform the patient and specify in writing the reasons for the delay and the earliest date, not later than **twenty-one working days** after receiving the request, when the information will be available for examination or copying."³ Such variability with respect to when the access request must be fulfilled often leads to variability in how quickly a covered entity fulfills an individual access request.

The length of time needed to fulfill an individual access request also depends on where information considered part of the record is stored and whether records are maintained electronically or in another

² Request for Information on Modifying HIPAA Rules to Improve Coordinated Care, 83 Fed. Reg. 240 (December 14, 2018). Federal Register: The Daily Journal of the United States. Web. 14 December 2018.

³ Wash. Rev. Code §70.02.080.

form such as paper and/or film. Under such circumstances, additional resources, including staff, are often required to potentially check multiple EHRs or off-site storage to pull the pertinent information within the timeframe required by state and/or federal law. In circumstances where a patient may have a long history of complex medical conditions and has requested their health information, this problem is compounded, as an extensive amount of information must be retrieved to ensure compliance with HIPAA and state law.

Furthermore, state and federal record retention laws can impact the timeframe needed to fulfill an individual access request. Currently, there is no uniform federal record retention schedule that healthcare providers and institutions must follow; we refer OCR to AHIMA's practice brief, "[Retention and Destruction of Health Information](#)," to provide examples of such variability at the federal level. A state may also have its own record retention requirements, which can differ depending on such factors as, but not limited to, the type of provider, age of majority, patient condition, and type of information contained in the record (e.g., labs, imaging, etc.)⁴ Accreditation requirements add an additional layer of complexity to the varying retention schedules. Because federal, state, and accreditation agency retention standards differ, this can often present challenges for HIM professionals by slowing the time it takes to fulfill an individual access request under 45 CFR 164.524.

2. How feasible is it for covered entities to provide PHI when requested by the individual pursuant to the right of access more rapidly than currently required under the rules? What is the most appropriate general timeframe for responses? Should any specific purposes or types of access requests by patients be required to have shorter response times?

In many instances, covered entities are able to provide PHI to an individual when requested pursuant to the right of access more rapidly than the allowable 30 days under HIPAA. AHIMA's members have noted that many of their institutions and/or release of information vendors have policies in place that seek to fulfill the individual's access request as quickly as possible, including a same-day turnaround. That said, there are instances in which fulfilling an access request might take longer, including up to the full 30 days allowed under HIPAA. For example, our members have experienced instances where a change in the institution's or practice's release of information vendor can temporarily extend the timeframe for fulfilling an individual access request to near the 30-day mark. Additionally, a lack in uniformity in how an individual access request is submitted to the covered entity may also create variability in the timeline needed to fulfill an individual access request. For that reason, it is difficult to approximate an appropriate general timeframe.

3. Should covered entities be required to provide copies of PHI maintained in an electronic record more rapidly than records maintained in other media when responding to an individual's request for access? If so, what timeframes would be appropriate?

AHIMA does not recommend that covered entities be required to provide copies of PHI maintained in an electronic record more rapidly than records maintained in other media when responding to an individual access request. Adding an additional timeframe in addition to the existing 30-day timeframe under HIPAA as well as state laws that have established deadlines for when a covered entity must furnish an individual with a copy of their record will create more complexity to the current patchwork of federal and state requirements, thereby increasing administrative burden on covered entities.

⁴ Available at: <http://www.healthinfolaw.org/comparative-analysis/medical-record-retention-required-health-care-providers-50-state-comparison>.

4. What burdens would a shortened timeframe for responding to access requests place on covered entities?

A shortened timeline for responding to individual access requests would likely increase the need for additional financial resources and staffing for facilities and clinicians to ensure that the requests are fulfilled within the time required under HIPAA. Again, while many HIM professionals prioritize individual access requests and are able to fulfill them in less than the 30 days required under HIPAA, the hybrid paper and electronic state of the medical record can slow the process at times, resulting in a longer timeframe to fulfill a request.

7. Should covered entities be required to disclose PHI when requested by another covered entity for treatment purposes? Should the requirement extend to disclosures made for payment and/or healthcare operations purposes generally, or alternatively, only for specific payment or healthcare operations purposes?

AHIMA recommends that covered entities should be required to disclose PHI when requested by another covered entity for treatment and payment purposes. AHIMA members note that instances persist in which a covered entity may be unwilling to disclose PHI even though the information is for the provision of care. We believe that if HIPAA is revised to require such a disclosure for treatment and payment, it would create a bright-line for covered entities and help facilitate the sharing of PHI for care coordination purposes. Additionally, we do not believe that such a change in the regulations would impose substantial administrative costs on covered entities, as the majority of covered entities today disclose PHI when requested for treatment purposes. That said, we are cognizant of existing state and federal law(s), such as 42 CFR Part 2, where the disclosure of certain types of health information, even for treatment purposes, are contingent upon a patient's consent. In such circumstances, if a covered entity were to withhold PHI for treatment and payment purposes because they lack the patient's consent, the covered entity should not be penalized under HIPAA. For that reason, we recommend that should OCR decide to require covered entities to disclose PHI for treatment and payment purposes, it should create a safe harbor provision for covered entities where PHI has been requested for treatment and payment purposes but state and/or federal law(s) prohibits the sharing of certain types of PHI without patient consent.

(b) Should any limitation be placed on this requirement? For instance, should disclosures for healthcare operations be treated differently than disclosures for treatment or payment? Or should this requirement only apply to certain limited payment or healthcare operations purposes? If so, why?

With respect to whether the requirement should extend to disclosures made for healthcare operations, AHIMA recommends that the requirement should extend to the specific healthcare operations activities of the recipient covered entity set forth under 45 CFR 164.506(c)(4). This would mean that the existing requirements under 45 CFR 164.506(c)(4) must continue to be met before the covered entity would be required to disclose the PHI for healthcare operations activities, including: (1) both covered entities must have or have had a relationship with the patient, (2) the PHI requested must pertain to the relationship, and (3) the discloser must disclose only the minimum information necessary for the healthcare operation at hand. Such a change will not only enhance care coordination but also ensure that the disclosed PHI is used for narrowly construed purposes. Additionally, we do not believe that such a change would dramatically alter existing workflow or cause tremendous additional administrative costs, as such disclosures are currently permitted under HIPAA.

(c) Should business associates be subject to the disclosure requirement? Why or why not?

AHIMA does not believe that business associates should be subject to the disclosure requirements because a business associate often provides a business function on behalf of the covered entity, (e.g., data conversion from one EHR to another, data destruction, internet service provider, etc.) and is not the creator of the data. Under such circumstances, requiring a business associate to disclose could muddy the chain of ownership of the PHI and create additional risk for the covered entity. Additionally, because the business associate may not have an existing business relationship with the recipient covered entity, additional time and resources may be needed to properly authenticate the request and to reach an agreement on a secure means of transmission—which, again, could create additional risk for the covered entity.

14. How would a general requirement for covered healthcare providers (or all covered entities) to share PHI when requested by another covered healthcare provider (or other covered entity) interact with other laws such as 42 CFR Part 2 or state laws that restrict the sharing of information?

A general requirement for covered entities to share PHI when requested by another covered entity could create confusion with state and federal laws such as 42 CFR Part 2 that restrict the sharing of information. We refer OCR to our response in Question 7 where we recommend that OCR consider establishing a safe harbor provision for covered entities in instances where state and/or federal law does not permit the sharing of certain types of PHI without a patient's consent.

15. Should any new requirement imposed on covered healthcare providers (or all covered entities) to share PHI when requested by another covered healthcare provider (or covered entity) require the requesting covered entity to get the explicit affirmative authorization of the patient before initiating the request, or should a covered entity be allowed to make the request based on the entity's professional judgment as to the best interest of the patient, based on the good faith of the entity, or some other standard?

From an HIM perspective, requiring the requesting covered entity to get the explicit affirmative authorization of the patient before initiating the request, provided the purpose is for TPO, would be an immense challenge to manage administratively. Such a requirement would likely be resource-intensive and require additional staffing. Patients may be unwilling to grant authorization for certain requests because they may not be aware of either how frequently their information is disclosed for TPO and/or the extent to which such information is shared. Managing such a process may become progressively more difficult as our healthcare ecosystem increasingly becomes more digitized and as data flows improve. Requiring a requesting covered entity to obtain the patient's authorization before initiating the request, provided the purposes are for TPO, will also delay care and further fragment care coordination as some consulting physicians today may be unwilling to see or schedule a patient until they have had an opportunity to review the patient's outside records. AHIMA recommends that OCR apply a consent regime similar to 45 CFR 164.506(b) and allow the requesting covered entity the flexibility to determine whether it should obtain the patient's consent prior to initiating its request to use information about the patient for treatment, payment, and healthcare operations. Whether the covered entity sought such consent would be based on the covered entity's professional ethics and best judgment. Taken with AHIMA's recommendation in Question 7(b) to require disclosures when requested by another covered entity for treatment, payment, and limited healthcare operations (provided the conditions of 45 CFR 164.506(c)(4) are met), this will ensure that PHI is shared for appropriate and necessary purposes with the requesting covered entity.

16. What considerations should OCR take into account to ensure that a potential Privacy Rule requirement to disclose PHI is consistent with rulemaking by the Office of the National Coordinator for Health Information Technology (ONC) to prohibit “information blocking” as defined by the 21st Century Cures Act?

AHIMA recommends that OCR not make any substantial changes to the requirements to disclose PHI under the Privacy Rule until ONC’s “information blocking” rule has been finalized. It is unclear the extent to which ONC’s forthcoming rule may address existing barriers to information sharing that currently hinder care coordination. Allowing the information blocking rule to be finalized will ensure that any disclosure requirements imposed by OCR are not duplicative and that changes under the Privacy Rule align with the requirements of the information blocking rule.

Promoting Parental and Caregiver Involvement in Addressing the Opioid Crisis and Serious Mental Illness

24. Are there circumstances in which parents have been unable to gain access to their minor child’s health information, especially where the child has a substance use disorder (such as opioid use disorder) or mental health issues, because of HIPAA? Please specify, if know how the inability to access a minor child’s information was due to HIPAA, and not state or other law.

In general, AHIMA members have found that state law is the main driver as to why parents are unable to gain access to their minor child’s health information versus HIPAA. AHIMA recommends consideration be given to harmonization and simplification of state laws to help facilitate appropriate parental access to their minor child’s health information in instances where the child has a substance use disorder or mental health issue(s). State parental consent and/or parental notification laws are often complex and any modifications to HIPAA might lead to further confusion, thereby having a direct impact on the ability of a child to receive the necessary care.

Accounting of Disclosures

27. How many requests for an accounting of disclosures do covered entities receive annually and from what percentage of total patients? Of these, how many requests specify a preferred electronic form or format, and to what extent do covered entities provide the accounting in the requested form or format?

AHIMA members have noted that the number of requests they receive is significantly low, receiving anywhere from 0-3 accounting of disclosure requests per year. Based on feedback from our members, this does not appear to vary across the size and type of the institution. Often times, the accounting of disclosures request is limited to a particular party or parties and not a request for all who may have accessed the record. For example, the patient may be concerned that a family member, friend, or former spouse obtained access to their record for an inappropriate purpose. Once it is explained to the patient that an accounting would not necessarily indicate whether such access occurred by the particular individual, the HIM professional transitions to performing an investigation into a potential privacy breach, including an EHR access audit to determine whether such access occurred. Such investigations, once completed, are generally performed to the satisfaction of the patient.

Additionally, the accounting of disclosure requests that are incurred by an institution generally do not specify a preferred electronic form or format.

28. How much time do covered entities take to respond to an individual's request for an accounting of disclosures? How many worker-hours are needed to produce the accounting? What is the average number of days between receipt of a request and providing the accounting to the requesting individual? How would these estimated time period change, if at all, if covered entities were to provide a full accounting of disclosures for TPO purposes? What is the basis for these revised estimates?

Given the rarity of accounting of disclosures requests, it is difficult to accurately extrapolate the amount of time it takes to respond to such a request. That said, under current conditions, the time it takes a covered entity to respond to an individual's request for an accounting of disclosures often depends on the activity or activities of the patient. For example, if the patient's activities consist of one emergency department visit, a manual abstract can be produced within 1-2 hours. However, if a patient has a long history of activities over six years, it might take at least one business day to perform a manual abstract of the patient's chart to determine where/when the patient's information was accessed. In general, HIM professionals try to produce the accounting of disclosures for the requesting individual within the same business day or next business day.

However, a recurring challenge is that despite the predominate use of EHRs, AHIMA members must frequently perform manual reviews of a patient's record because not all disclosures are documented within the EHR or found in the same place. For example, HIM professionals may also look for requests from the state, law enforcement, court orders, other departments within the institution, registries, etc., all of which may not be documented within the EHR due to lack of EHR functionality. Alternatively, if a HIM professional is dealing with multiple EHR systems, the information may reside in different places within each EHR system. For that reason, we are concerned that the estimated time period would substantially lengthen if a full accounting of disclosures for TPO purposes would be required, because much of the current work around fulfilling an accounting of disclosures continues to be done manually.

31. Should the Department require covered entities to account for their business associates' disclosures for TPO, or should a covered entity be allowed to refer an individual to its business associate(s) to obtain this information? What benefits and burdens would covered entities and individuals experience under either of these options?

AHIMA recommends that OCR should clearly state in any final rule that the contract terms of the business associate agreement should guide whether the business associate or the covered entity accounts for the business associates' disclosures for TPO. We are concerned that if a covered entity were required to account for all of their business associates' disclosures for TPO, it would create tremendous burden on the covered entity to produce such an accounting, as the covered entity may work with many different business associates in the general course of business.

At the same time, if business associates were required to produce such information, we are concerned that patients may not fully comprehend the different kinds of work that business associates perform on behalf of a covered entity, and such a requirement would require the creation of many new lines of communications between an individual and the covered entity's business associates. We are also concerned that such a requirement could further slow the accounting process, lengthening the time it takes to fulfill an individual's request for an accounting of disclosures for TPO. Allowing the terms of the

business associate agreement to dictate which entity may/should account for the business associates' disclosures for TPO would give the covered entity the flexibility to maintain manageable lines of communication with the patient while limiting administrative burden for both the covered entity and their business associates.

AHIMA's recommendation would also align with the existing requirements under the HIPAA individual right of access guidance when the PHI is maintained by a business associate of a covered entity, which would help to reduce confusion in complying with the individual right of access and the accounting of disclosures for TPO under HIPAA.⁵

37. What data elements should be provided in an accounting of TPO disclosures, and why? How important is it to individuals to know the *specific* purpose of a disclosure –i.e., would it be sufficient to describe the purpose generally (e.g., for “for treatment,” “for payment,” or “for healthcare operations purposes”) or is more detail necessary for the accounting to be of value? To what extent are individuals more familiar with the range of activities that constitute “healthcare operations”? On what basis do commenters make this assessment?

AHIMA recommends that describing the purpose generally (i.e., “for treatment,” “for payment,” or “for healthcare operations purposes”) strikes the best balance between administrative burden on the covered entity and value to the patient. Additional data elements, including the specific purpose of the disclosure, would be time-consuming and resource intensive for HIM professionals and leave the patient without a clear understanding of the complex data flows that occur as covered entities seek to improve patient care and enhance care coordination.

39. If covered entities are unable to modify existing systems or processes to generate a full accounting of disclosures for TPO, (e.g., because modification would be prohibitively costly), should OCR instead require covered entities to conduct and document a diligent investigation into disclosures of PHI upon receiving an individual's request for an accounting of disclosures for TPO? If not, are there certain circumstances or allegations that should trigger such an investigation and documentation by a covered entity? How much time should a covered entity be allowed to conduct and provide results of such an investigation?

AHIMA suggests that OCR should require covered entities to conduct and document a diligent investigation into disclosures of PHI in lieu of providing a standard accounting of such disclosures. Such a requirement would generally align with existing obligations, policies, and procedures that are acted upon when an individual requests an accounting of disclosures (even when the request may transition into an investigation of a potential privacy breach).

40. If OCR requires or permits covered entities to conduct an investigation into TPO disclosures in lieu of providing a standard accounting of such disclosures, what information should the entities be required to report to the individual about the findings of the investigation? For example, should OCR require covered entities to provide individuals with the names of the persons who received TPO disclosures and the purpose of the disclosures?

Requiring covered entities to provide individuals with the names of the persons who received TPO disclosures would create tremendous administrative burden on HIM professionals, as patients may not

⁵ Available at: <https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html>.

have a clear understanding of why so many persons may have received TPO disclosures. As a result, HIM departments may be inundated with patient requests for further investigations to find out additional information about these disclosures, requiring additional resources to meet such requests.

Alternatively, AHIMA recommends that if OCR requires entities to report to the individual about the findings of its investigation, covered entities should be required to report no more than the general purpose for which the information was disclosed, (e.g., “for treatment,” “for payment,” “for healthcare operations”) and the department(s) to which the information was disclosed. Additional information might include a stipulation that the investigation was completed, and no inappropriate disclosures occurred. In the event that an HIM professional determines a privacy breach occurred, he or she would follow the existing breach notification requirements under HIPAA. Such requirements would align with existing access control management policies in place at many institutions and practices.

41. The HITECH Act section 13405(c) only requires the accounting of disclosures for TPO to include disclosures through an EHR. In its rulemaking, should OCR likewise limit the right to obtain an accounting of disclosures for TPO to PHI maintained in or disclosed through an EHR? Why or why not? What are the benefits and drawback of including TPO disclosures made through paper records or made by some other means such as orally? Would differential treatment between PHI maintained in other media and PHI maintained electronically in EHRs (where only EHR related accounting of disclosures would be required) disincentivize the adoption of, or the conversion to, EHRs?

AHIMA recommends that OCR limit the right to obtain an accounting of disclosures for TPO to PHI maintained in an EHR. The effort and resources needed to account for such disclosures outside of an EHR would be cost-prohibitive, requiring additional staff resources, and could lead to unwieldy workflows. To avoid increasing the burden on covered entities without providing real benefits to patients, OCR should clearly state in any final rule that disclosures for TPO are exempt from accounting for disclosures requirements except in cases where those disclosures are made through an EHR (and clarify what specific types of healthcare operations are included).

Notice of Privacy Practices

52. Are there modifications to the content and provision of NPP requirements that would lessen the burden of compliance for covered entities while preserving transparency about covered entities’ privacy practices and individuals’ awareness of privacy rights? Please identify specific benefits and burdens to the covered entity and individual and offer suggested modifications.

In general, AHIMA members have found that there is not tremendous burden in making a good faith effort to obtain an individual’s written acknowledgement of receipt of the provider’s NPP. However, our members note that there is an actual cost associated with providing the NPP whether the information is provided to the patient in paper format or, in facilities that offer telemedicine visits, additional programming that must be added to make the NPP available.

That said, the content of the NPP remains relevant and critical to the patient experience in that it is a valuable tool in understanding, among other things, how their information is used, where to file a complaint, and how to obtain a copy of their records. For that reason, AHIMA recommends that OCR consider modifications to the method(s) by which the NPP is shared with the patient, particularly as healthcare continues to shift away from a paper-based world.

We appreciate the opportunity to submit comments on the Request for Information on Modifying HIPAA Rules to Improve Coordinated Care. We hope that your office will continue to engage extensively with stakeholders on these critical issues and we look forward to working with OCR on the successful revisions to HIPAA where necessary to foster further transformation to value-based healthcare. Should you or your staff have any additional questions or comments, please contact Lauren Riplinger, Senior Director, Federal Relations, at lauren.riplinger@ahima.org and (202) 839-1218.

Sincerely,

A handwritten signature in cursive script that reads "Wylecia Wiggs Harris".

Wylecia Wiggs Harris, PhD, CAE
Chief Executive Officer
AHIMA