

**Comments of the
National Association of State Mental Health Program Directors**

In Response to a Proposed Rule
Published in the Federal Register (March 27, 2002)

**Standards for Privacy of Individually
Identifiable Health Information;
Proposed Rule**

Submitted April 26, 2002 to:

U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Privacy 2
Hubert H. Humphrey Building, Room 425A
200 Independence Avenue, SW
Washington, DC 20201

INTRODUCTION

The National Association of State Mental Health Program Directors (NASMHPD) represents the \$23 billion public mental health service delivery system serving 6.1 million people annually in all 50 states, 4 territories, and the District of Columbia. On behalf of NASMHPD, we hereby submit the following comments in response to the Notice of Proposed Rulemaking published in the March 27, 2002 *Federal Register* implementing the medical records confidentiality provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

COMMENTS ON THE PROPOSED RULE

NASMHPD applauds the Department of Health and Human Services (HHS) ongoing efforts to ensure that consumers of health care services – including mental health services – have a right of confidentiality in their medical records. In general, NASMHPD believes that individually identifiable information should be released only with the informed, non-coerced consent of the consumer. Ensuring privacy of this information is critical to encourage people with mental disorders to seek treatment and participate fully in their treatment plans.

Treatment, Payment, and Health Care Operations

NASMHPD recognizes that the sharing of some personally identifiable information among direct care providers under carefully defined circumstances is a critical component of providing health care in an efficient, integrated service delivery system. We appreciate your efforts to ensure that medical privacy requirements do not create obstacles to effective treatment or undermine sound clinical practice.

NASMHPD is concerned about provisions in the Final Rule on medical privacy, which became effective April 14, 2001, requiring covered health care providers with a direct treatment relationship with the patient to receive a written consent from the patient before sharing protected health information for treatment, payment or health care operations. Permitting the exchange of protected health information for treatment purposes is especially important in the public mental health system, which is responsible in most states for providing a broad range of mental health services – including inpatient care, outpatient services, and community supports. This treatment may take place in many separate treatment settings and involve many providers, and successful outcomes often will depend on communication and coordination among those providers. The exchange of information among providers who are reasonably and appropriately involved in the provision of care is vital to ensuring continuity of care among providers, reducing the risk of adverse medication outcomes, ensuring the physical safety of the individuals and others sharing the service facility, and planning appropriate discharges.

While many of the exceptions in the Final Rule are helpful in minimizing the risk that patient care could be negatively affected by barriers to communication among providers, there remain important ambiguities that could disrupt the circumstances under which providers in the public mental health system routinely share information in the best interests of the patient. Therefore, we support the NPRM's proposal to eliminate the requirement for providers to obtain prior consent in order to share protected health information for these important treatment purposes. See §164.506.

In addition to eliminating the consent requirement for purposes of a covered entity's own treatment, payment, and health care operations or for another provider's treatment purposes, the NPRM also

proposes to permit a covered entity to disclose protected health information to another covered entity for specified health care operations, as long as both entities have a relationship with the patient. These purposes include quality assessment and improvement, outcomes evaluation, case management and care coordination, provider credentialing and performance evaluation, and detecting fraud and abuse. This provision would permit state mental health agencies to continue their important monitoring, oversight, and quality improvement functions with respect to the myriad of community providers involved in providing comprehensive services to individuals with mental illnesses, and we support this proposal.

We note that many states have laws that require consent to share protected health information, even for treatment, payment, and health care operations, relying on their own mechanisms to ensure that their laws do not impede the exchange of important clinical information. We strongly support the Secretary's proposal to permit states to enact and continue to enforce more stringent requirements.

Parents' Access to Minor's Medical Records

The NPRM purports to clarify provisions in the Final Rule regarding access by a parent (or guardian or other person acting *in loco parentis*) to the medical records of unemancipated minors. However, the NPRM in fact proposes significant changes to these provisions in the Final Rule that could discourage minors from seeking or receiving needed mental health treatment. See §164.502(g)(3).

The Final Rule generally permits parents to access their unemancipated minor's medical records, with or without the minor's consent. However, the Final Rule defers to state law under several circumstances, explicitly providing privacy protections for minors where state law permits the minor to access treatment without a parent's consent.

Although the NPRM apparently was designed to simplify the rules regarding parental access to minors' records, in fact it proposes a confusing, bifurcated approach that raises new concerns and ambiguities. First, the NPRM generally would permit but not require covered entities to disclose a minor's medical records to the minor's parent, but would defer to state law where the law either permits or requires disclosure to a parent. Covered entities would be barred from disclosing a minor's protected health information only where state law specifically prohibits such disclosure. Second, the NPRM provides that parents could access their minor's medical records so long as that access is consistent with state or other law, regardless of whether the law is explicit.

Our concern is that the NPRM does not retain the Final Rule's privacy protections for a minor's medical records in those states where minors are able to seek medical treatment without the consent of their parents. Although the NPRM is not clear with respect to who would decide whether to disclose or provide access to a minor's records, the preamble suggests that providers generally would decide so long as their decision was permitted by and consistent with state law.

Many states have adopted laws ensuring that minors may seek and receive mental health treatment without the consent of their parents. Implicit in those laws is an assumption that certain medical records documenting that treatment will not be released to or made available to the minor's parents. Permitting parents to have access to those records would directly undermine that policy and have the significant, negative consequence of discouraging minors from seeking important and even life-saving mental health treatment. The Secretary should ensure that the spirit and intent of state laws permitting minors to access treatment without parental consent is maintained in the medical privacy regulations.

De-Identification “Safe Harbor”

Both the Final Rule and the NPRM intend to protect health information that is “individually identifiable.” Information is not considered to be individually identifiable if it in fact does not identify an individual and if the covered entity has no reasonable basis to believe that the information can be used to identify an individual.

In acknowledging that it is not always possible to know *a priori* whether or not certain information can be used to identify an individual, the Final Rule provides a “safe harbor,” within which covered entities may presume that information is de-identified. Essentially, information that does not contain any of a list of 18 specific identifiers may be presumed to be de-identified. §164.514(b).

In the NPRM, HHS noted that many commenters to the Final Rule suggested that the list of identifiers is too lengthy and will act as a barrier to legitimate research and data analysis projects. As suggested by HHS, we would support development of a separate safe harbor for information to be disclosed only for purposes of research, public health, and health care operations. In particular, we note that certain elements of an individual’s address, such as his or her county or zip code, and an individual’s date of birth likely would not be individually identifiable and should be included in this limited data set.

ISSUES NOT ADDRESSED BY THE NPRM

Several issues identified by NASMHPD in previous medical privacy rulemaking proceedings and comment solicitations were not addressed in the NPRM. We urge HHS to incorporate the following recommendations into the privacy rule:

Preemption Exceptions

The Final Rule permits any person or entity to request an exception to preemption of state law. §160.204. In such instances, such a request may be inconsistent with state policy or enforcement strategies. We urge you to limit entities that may request a preemption exception to include only states and state governmental units. At a minimum, privacy regulations should provide a clear process for notifying states that an exception has been requested and give states an opportunity to respond before the Secretary issues a decision.

Patient Access To His Or Her Own Medical Records

The Final Rule permits qualified providers to refuse to grant a patient access to his or her medical records only if the provider believes that the access requested is “reasonably likely to endanger the *life* or *physical safety* of the patient or another person.” (emphasis added) §164.524(a)(3)(i). In very limited circumstances, however, significant potential for severe psychological or other severe harm may also indicate that patient access to his or her records should be limited. Explicitly restricting this provision to issues of physical safety fails to recognize the potential for severe mental harm that could significantly disrupt a patient’s progress toward recovery from mental illness. This harm could also result in suicide or other violence, even in those cases in which the provider was not comfortable in predicting *a priori*

that disclosing the information was “reasonably likely” to endanger the life or physical safety of the patient or another person.

Several state laws provide excellent examples of laws that are narrowly constructed and provide safeguards against overuse or abuse. For example, New York’s statute permits providers to refuse to grant access to a patient’s medical record if the provider believes that such access “can reasonably be expected to cause substantial and identifiable harm to the patient or client or others.” In making a determination, providers may consider such factors as (1) the need for, and the fact of, continuing care and treatment; (2) the extent to which the medical record contains sensitive information disclosed in confidence to the provider by family members, friends, or others with a personal relationship with the patient; and (3) the age of the patient. If access is denied, the provider must grant access to a prepared summary of the record. Patients may appeal a provider’s decision to deny access to a clinical records access review committee established by statute. See NY Mental Hygiene Law §33.16.

CONCLUSION

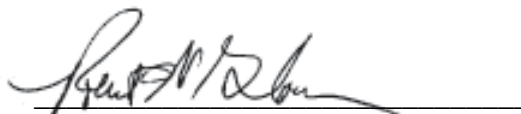
We appreciate HHS’ ongoing efforts to articulate and support a right of confidentiality for consumers in their medical records without undermining effective treatment in an efficient, integrated health care system. In particular, we appreciate improvements proposed in the March 27, 2002 NPRM to ensure that providers will be able to share health information as needed to provide effective treatment and continuity of care.

We thank you, in advance, for your careful consideration of these comments. Should you have questions or need additional information, please don’t hesitate to contact either of the undersigned or Jenifer Urff, NASMHPD’s Senior Policy Counsel (413/587-2418).

Respectfully submitted,



Tom Barrett, Ph.D.
President
(303) 866-7401



Robert W. Glover, Ph.D.
Executive Director
(703) 739-9333, ext. 129