1. Is an electronic file size an appropriate proxy for "pages" in setting fees for electronic access, or is it simply a substitute for a per-page proxy? No. If file size is appropriate, how should cost be calculated, particularly considering the questions below? If not, what is a better proxy for calculating labor costs for electronic access?

   Electronic file size is not an appropriate proxy for "pages" in setting fees for electronic records, and does not correlate to number of pages for at least three reasons: (1) many electronic health record systems ("EHR") store information differently than page-by-page, and different than images. Only a finite bit of data/type of item might be stored on one page. For that reason, some records printed from an EHR are more voluminous than they would be if reproduced from a paper chart; (2) many factors affect file size, including the tools used to extract information from the EHR, the scanning methods used to import images into an EHR, and the quality of the document output, which can be improved or degraded by using incorrect settings; in other words, electronic file size varies greatly based on reasons other than the actual content of the records; and (3) the cost to produce copies of records on paper includes labor, which involve many factors other than just the supply/paper cost for reproduction; likewise, electronic records also require labor in order for a record to be disclosed – regardless of the storage media or the way in which it is produced. Labor includes compiling, extracting, reviewing pages for minimum necessary, as required, scanning, burning the data onto media, and affixing postage/distributing media (i.e., shipping or postage fees).

   IOD and HealthPort each recently conducted time studies in the presence of representatives from the Seattle (Region X) OCR office, which showed that the amount of labor necessary to produce records from an EHR was the same as the labor necessary to produce records from paper, meaning that those who believe the EHR is a faster process are incorrect. These time studies resulted in per-page rates being submitted using a tiered application based upon the reduced amount of labor necessary after a certain number of pages were reproduced. There is no difficulty in calculating page counts and billing electronic files by the page. However, there is a public perception problem in billing per page when an electronic file is received. Hence, AHIOS members do not suggest using the size of an electronic file as a proxy for billing per page. Instead, we believe it would be more appropriate to include a statement that per-page billing for an electronic file remains a proper pricing methodology.

2. One of the objectives of Stage 2 of the Meaningful Use EHR Incentive Program is to provide individuals the ability to view, download and transmit their health information.[1] Therefore, should the producible form and format of the electronic copy the individual requests affect how the individual is charged? No. (For example, an individual downloads an electronic copy onto a portable thumb drive or CD vs. using the download or transmit capabilities of certified EHR technology or email.) This issue may also arise when an individual uses personal health records or mobile health devices.

The cost of the media is negligible compared to the labor costs of actually producing the record in compliance with the requirements of applicable laws. However, the most troublesome issue implied in this scenario is that a health care provider cannot allow "foreign" media to be inserted into or made a part of its record system due to unacceptable security risks. In order for an individual to "view" her/his records in this way, the records must be downloaded FIRST (by the provider or its HIM services provider), likely to a computer with no other records stored on it (such as a "dumb terminal"). Then, the individual can insert a flash drive into that computer and download her own records. In order for that to happen, most of the labor of producing a record has to have already been performed. The same can be said for downloading the records to a CD/DVD. The end-product media type, to be appropriately priced, must include the labor that occurred in getting the record to that point. One cannot simply bill for "a CD" or for "a flash drive."

3. If, due to interoperability issues between an EHR where the requested information is maintained, and the software used to create the copy for the individual (for example, proprietary software of a business associate which provides the electronic copy to the individual), the business associate must download the file from the EHR, and subsequently upload it to the business associate's software before generating an electronic copy for an individual, should labor costs associated with this process be charged to the individual? Yes.

   Why or why not? In some respects, business associates address the interoperability gap. Therefore, business associates should be able to collect for labor in performing the tasks mentioned above (downloading the file from the EHR and uploading it to the business associates' software for transmission to the recipient). In a world lacking interoperability, AHIOS members have the ability to create a file from the EHR that is consumable by any recipient, including other providers. The labor involved in creating the consumable file should be billable because, until interoperability is achieved, members will facilitate transfers of readable medical records to all requesters. Furthermore, most AHIOS members have secure web portals for delivery of electronic records to patients that many providers do not have, so we provide an end-user experience that many providers currently do not provide. While members are not retained to address interoperability issues, they do facilitate recipients obtaining records when they have no means to read the original EHR file. Additionally, in order for providers and business associates to maintain a work force which must be adequately compensated, all labor costs permissible under existing rules and regulations must be accounted for. Most large providers have many HIM employees, or else their business associates provide many employees, who work solely within the medical records department. Considering that many actual cost factors are NOT allowed under HIPAA to be charged to individuals, it is unfair to providers and their business associates to force them to invest in unreimburseable expenses.

   If so, how should they be calculated? Additionally, if the information is located in several different EHRs, downloaded, and uploaded to a separate software or system, should labor costs associated with this process be charged, as well – and if so, how should they be calculated? Yes, associated labor costs should be included. If the rules stay the same and only

certain categories of costs are reimburseable, those categories must be enlarged to include the actual costs of producing records for individuals. Accessing multiple EHRs, downloading the records, and uploading them again, are part and parcel of the actual costs involved. Certainly providers and their business associates should be reimbursed for such labor. If the time-study methodology is the one used, then compensable time would increase for such labor. The methodology recently submitted by the HIM release-of-information/disclosure management industry (led by the HealthPort/IOD team) should be seriously considered and expanded to allow for such additional costs. One method for calculating the additional costs of this scenario would be to allow a flat compilation fee for the multiple downloads, uploads, etc. from each EHR where records are located.

4. Similarly, if information from an EHR has to be printed on paper (therefore paginated) and then scanned and uploaded to a different software program used to create and/or send the copy for/to the individual, should the individual be charged, and if so, how should the cost be calculated? Since the Commentary on the electronic access requirement [78 Fed.Reg. No. 17 at 5633 (Jan. 25, 2013)] states "We clarify that covered entities *are not required to scan paper documents to provide electronic copies of records maintained in hard copy*," we assume that printing a hard copy from an EHR, and then uploading it to software solely to make it electronic, would similarly not be required. If an EHR is incapable of producing a copy for an individual in electronic format, the request for an electronic copy should be allowed to be denied. If it is OCR's position that such machinations are required, then naturally the costs associated with that process should be allowed, and could be calculated as a flat fee for compilation, as referenced in #3 above.

5. Would you answer anything differently if the copy of the data from the designated record set were being transmitted to a non-HIPAA covered business associate, such as a PHR vendor compared to another HIPAA covered entity or that organization's business associate? Most requesters of medical records are not business associates. If such a requester has a patient authorization, then states' statutory or regulated rates generally are charged (except for those requesters who are various government agencies or in special circumstances such as criminal subpoenas, records delivered to physicians for continuing care, etc.). Separately, contract pricing applies to records supplied to payers for certain special projects. Often the designated record set is not requested because insurance records are not maintained along with medical records; they are kept separately in the business office or departments known as "Patient Financial Services" or a similar name. If a patient directs a copy of her/his records to a PHR vendor, it should be handled as a patient request at the same rates as other patient requests.