MGMA
Medical Group Management Association

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National Coordinator
Office of the National Coordinator for Health Information Technology
Department of Health and Human Services
Hubert H. Humphrey Building, Room 517D
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Sub-regulatory guidance on charges/fees to provide electronic copies of health information

Dear Dr. DeSalvo:

On behalf of our 33,000 national and state affiliate members, the Medical Group Management Association (MGMA) appreciates the opportunity to provide input on the issue of charges/fees to provide electronic copies of health information. MGMA is supportive of the right of patients to gain access to an electronic copy of their medical record. Not only is this a regulatory requirement, but also imperative for building successful provider-patient relationships. The challenge here remains appropriately balancing the need for patients to have access to their medical record while avoiding imposing excessive administrative requirements and cost on covered entities.

As the leading association for medical practice administrators and executives in practices of all sizes, types, structures and specialties since 1926, MGMA helps improve members' practices through exclusive member benefits, education, resources, news, information, advocacy, and networking opportunities, and produces some of the most credible and robust medical practice economic data and data solutions in the industry. MGMA advances the profession of medical practice management with its industry-leading board certification and Fellowship programs through the American College of Medical Practice Executives.

General comments

- The final HIPAA Omnibus Rule (Section 164.524) clearly permits covered entities to identify separately the labor for copying protected health information, whether in paper or electronic form, as one factor that may be included in a reasonable cost-based fee. It clarifies that labor costs included in such fees could include skilled technical staff time spent creating and copying the electronic file, including compiling, extracting, scanning and burning protected health information (PHI) to new media, and subsequently distributing it. Time spent preparing an explanation or summary of the PHI is also permitted to be counted towards these fees, if appropriate.

- Cost of supplies for creating the paper or electronic copy, including physical media such as a compact disc (CD) or universal serial bus (USB) flash drive, is also permitted to be

separately charged under the Omnibus Rule. However, the rule does not require covered entities to obtain new types of technology in order to comply with specific individual requests. Therefore, the cost of obtaining such new technologies would not be a permissible fee to include in the supply costs.

- A covered entity must follow all state laws when setting fees. Adding to general confusion for medical groups, many states set limitations on standard fees, labor costs, and reasonable per-page fees that can be charged for providing the patient with a copy of their medical records. Under HIPAA's preemption rules, if HIPAA is stricter than state law, then HIPAA prevails. Medical groups must therefore weigh the stipulations set forth in state law against the parameters established under HIPAA. Establishing clear guidelines would be extremely helpful for medical groups.

- In many cases, patients may not want their entire medical record to be provided to them, either on paper or electronically. This is an important consideration when discussing the assignment of cost. Every effort should be made by the covered entity to determine what components of the medical record the patient wants and needs. For example, some patients may only want their most recent lab results, yet may be provided the entire medical record and thus incur significant costs. For patients moving from one provider to another, they may want their entire record to move with them, and therefore are willing to incur the full cost of reproduction. Determining what elements of the record the patient requires will make it easier and less expensive for both the provider and the patient.

- Subsequent record requests by patients also requires addressing. For example, if providers are only permitted to charge limited fees up to a certain amount over a given period of time, this may not cover the full cost of the reproduction when multiple copies are requested. ONC should consider adopting a policy of increasing the amount of fees permitted when a patient multiple copies of the same medical record within a designated time period.

- Policy makers must also address this issue of electronic copies of medical records as it pertains to the new patient portals requirement under the EHR Incentive (meaningful use) Program. Significant, ongoing costs are incurred maintaining a portal, often in the range of tens of thousands of dollars, even for smaller practices. Further, many of these portal products are neither intuitive nor user-friendly for the practice or the patients. As a result, some practices have had to incur additional expense contracting with another vendor or expending practice staff time assisting patients in navigating the portal. These costs, while significant, are unable to be recouped by the organization through fees charged to the patient for access to their medical record. Therefore, we urge that the ongoing costs of making these systems available be factored into Medicare and Medicaid reimbursement, as these costs will continue long after the meaningful use incentives are gone.

ONC questions and MGMA responses

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? 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?*

   MGMA response:
   We do not believe that file size is an acceptable proxy for "pages." With electronic files, there is little difference in cost between a large electronic file and a small one, in terms of storage space. However, the difference impacting cost between a large and small electronic file comes into play in two ways. First, the larger the file, typically the longer it takes for practice staff to download or compile. Second, storage media (i.e., CD, USB flash drive) costs may be higher for the larger file (i.e., the cost for a 16GB USB flash drive may be higher than an 8GB version). This is especially true for certain components of an electronic medical record, such as radiologic images, which may require substantially more storage space. Thus, we contend that a more accurate proxy for calculating costs for electronic access would include the following:

   - Reasonable labor costs for copying PHI, whether in paper or electronic form, including staff time spent creating, copying, scanning, and burning PHI to storage media

   -Costs of supplies (e.g., CDs, USB flash drives) or postage should the patient request the media be mailed

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. Therefore, should the producible form and format of the electronic copy the individual requests affect how the individual is charged? (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.*

   MGMA response:
   Regarding the issue of whether the producible form and format of the electronic copy requested should affect how the individual is charged, we believe the answer is yes. While the Omnibus regulation requires that the covered entity provide a means for the individual to receive an electronic copy of their medical record, and further states that the covered entity must make an effort to accommodate the patient's request for the information to be supplied in a particular form and format, it balances that with the caveat that the covered entity is not expected to incur "undue burden or cost." Should the patient request a format that is not easily accommodated by the covered entity, such as a particular brand of storage device, the covered entity should be permitted to charge the patient a reasonable amount for purchase of that device.

Further, securing the data so that only the patient can open the electronic file remains an issue. Assigning reasonable labor costs for encrypting purposes should be permitted if the patient requests that the storage device be secured.

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? Why or why not? 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?*

   MGMA response:
   It is becoming increasingly common that medical groups, especially larger ones, store patient information in multiple electronic systems. Consequently, some medical groups may contract with third party business associates to provide an electronic copy of the medical record to the patient. In both of these situations, the covered entity incurs the cost of staff time necessary to compile and store the information. Understanding there may be cases in which the configuration of the health organization requires additional staff time to compile a medical record located in multiple systems, and that the covered entity should be permitted a charge a reasonable fee, the cost for compiling the record should not pose a significant barrier to the patient receiving their medical record.

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?*

   MGMA response:
   It remains unclear what percentage of EHRs require this two-step process for providing patients with a copy of their medical record. It does not seem reasonable to pass onto the patient all of the labor costs associated with the secondary scanning due to how the EHR is designed. However, if the patient requests a particular format (i.e., paginated and/or in a particular order) that would require the covered entity to print and scan the pages into a new electronic file, then additional charges related to that specific additional printing and scanning effort should be permitted.

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?*

MGMA response:
With regard to the issue of a covered entity transmitting, at the request of a patient, a medical record to a non-HIPAA covered entity, such as a PHR vendor, covered entities should be permitted to charge reasonable fees to cover the cost of additional staff time spent compiling and sending the information and ensuring the security of the transmission.

We thank you for the opportunity to provide comments on this very important issue. MGMA looks forward to continuing our work with ONC to facilitate the development of effective policies to ensure that the promise of improving the nation's healthcare system through the deployment of appropriate technology becomes a reality. Should you have any questions regarding these comments, please contact Robert Tennant, Director of HIT Policy for MGMA, at 202.293.3450 or rtennant@mgma.org.

Sincerely,

Anders Gilberg

Senior Vice President, Government Affairs

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