Minnesota Health Information Exchange
 Legislative Study Request for Public Comment

BACKGROUND AND PRELIMINARY RECOMMENDATIONS FOR PUBLIC COMMENT, 10/2/17

The Minnesota Department of Health (MDH) is seeking public comment on draft recommendations for a legislative study on health information exchange (HIE) in Minnesota.

Released: October 2, 2017
Responses due: October 31, 2017, by 5:00 p.m. CDT
For questions, please email MN.eHealth@state.mn.us.

Table of Contents

Introduction ............................................................................................................................. 1
About Health Information Exchange ......................................................................................... 3
A Proposed Solution ................................................................................................................ 10
Preliminary Recommendations ................................................................................................. 13
Appendix A: Questions for Public Comment ....................................................................... 15
Appendix B: HIE Study Project Team and Steering Team ..................................................... 16
Appendix C: Recommendation #1, Task Force Detailed Plan Topics .................................. 17
Appendix D: Assessment of the Consent Requirements in the Minnesota Health Records Act and Menu of Options ................................................................. 18

Introduction

The 2016 Minnesota Legislature requested a study to assess Minnesota's legal, financial, and regulatory framework for health information exchange (HIE), including the requirements in Minnesota Statutes, Sections 144.291 to 144.298 (the Minnesota Health Records Act), and make recommendations for modifications that would strengthen the ability of Minnesota health care providers to securely exchange data in compliance with patient preferences and in a way that is efficient and financially sustainable.

This request was made based on recommendations from the 2015 Health Care Financing Task Force\(^1\) that addressed barriers to data sharing that can better support patient care and accountable payment models.

\(^1\) Available at: https://mn.gov/dhs/assets/final-materials-final-report_01-28-2016_tcm1053-165972.pdf
This study used information collected through surveys, interviews and conversations with Minnesota’s health systems, health plans, providers, and health information exchange vendors and organizations. Complete methodology will be provided in the final legislative report.

Who should respond?

While this request for public comment is open to any individual or organization that chooses to respond, the target audience includes:

- Health care providers and provider organizations from all specialties and sizes.
- Individuals, patients and caregivers.
- Payers, purchasers and health plans.
- Non-clinical community organizations, neighborhood based agencies or social service organizations that are or will be partnering with clinical health care providers to coordinate care for patients or populations.
- Vendors of electronic health records and health information exchange solutions.

Procedures and instructions for responding

This request for public comment includes specific questions for which MDH is seeking comment. Responders can choose to address any or all of these questions presented in Appendix A, and additional comments are welcome.

To be assured consideration, comments must be received no later than 5:00 PM Central Time on October 31, 2017. Please e-mail an electronic copy of your response to MN.eHealth@state.mn.us. Use the subject line: “HIE Study Comment.” Comments may be submitted as email text or an attachment, preferably in formats such as Adobe PDF, Microsoft Word, or universally-convertible word processing format (e.g., text, rich text file).

Respondents are responsible for all costs associated with the preparation and submission of responses to this request. All responses to this request are public, according to Minnesota Statutes § 13.03, unless otherwise defined by Minnesota Statutes § 13.37 as “Trade Secrets.” If a Respondent submits information that it believes to be trade secret, and the Respondent does not want such data used or disclosed for any purpose other than the evaluation of its response, the Respondent must clearly mark every page of trade secret materials in its response at the time the response is submitted with the words “Trade Secret” and must justify the trade secret designation for each item in its response.

Background

Health providers in Minnesota have largely moved into using electronic record systems, commonly referred to as electronic health record (EHR) systems. All of the state’s hospitals and the vast majority of clinics, nursing homes and local public health agencies use EHRs. Other settings across the care continuum are increasingly implementing electronic systems. Most Minnesotans’ patient information is currently stored in electronic systems, but usually in systems managed independently by each of their providers (or the provider’s health system). Patients who see a variety of providers – e.g., who move between different health systems – don’t have their collective health information easily available in a comprehensive way unless that information moves electronically, referred to as health information exchange, or HIE.
Definitions:
- HIE (the verb) is the electronic transmission of health-related information between organizations (assuming the person has provided consent to share the information).
- HIE (the noun) is an organization that facilitates information exchange. Several of these operate in Minnesota.

Patients need their information to go with them between different health care organizations in order for their providers to make care decisions in a timely and efficient manner. This can happen, for example, when someone is referred to a specialist or transitions from a hospital to nursing home (or to home care). Without this flow of information, patients may receive repeat exams/tests, need to repeatedly describe their situation to multiple care providers, deal with uncoordinated care, face care delays, and potentially receive poor care. At a fundamental level, a patient needs to know that his or her health information can be easily and securely shared with any providers he or she chooses.

Many health care organizations in Minnesota are also participating in risk/reward sharing and/or total cost of care payment arrangements with health plans and payers that require effective and efficient sharing and use of information. As an example, the Minnesota Department of Human Services currently has Accountable Care arrangements with 21 demonstration partnerships. These partnerships are providing health care at a lower cost to more than 465,000 Minnesotans enrolled in Medical Assistance. CMS also has seven Medicare Shared Savings Programs and two Medicaid Pioneer ACO models in Minnesota. These accountable care and similar organizations understand the need to use information to manage care costs by coordinating care, addressing root problems associated with a person’s social determinants of health, and having timely access to information on all of the care a person receives.

About Health Information Exchange

Health information exchange (HIE) allows providers to securely share information with other providers or organizations according to patient preferences. Minnesota has some HIE happening, but it is not happening equitably nor robustly across the state. This means that some health organizations can exchange with some others, but not all others. To have effective HIE, we need to have every health organization participate with each patient having an option to participate.

HIE can be used for a variety of reasons depending on the needs of the patient, the patient’s care providers, the health plan or payment contract, local public health, and communities. HIE can support better care and health for individuals and communities. Exhibit 1 portrays how HIE can be thought of in the context of a home. At a foundational level, information needs to go where the patient goes. With that established, more robust HIE uses information from across the care continuum to support care coordination, improved outcomes, and learning. Optimal HIE allows data to be connected across networks to better understand the health of our communities. These concepts are described below.
**Foundational HIE: Information flows with the patient**

Foundational HIE means that a person’s health information flows with him/her during transitions of care, such as a hospital discharge or referral to another provider. Health providers can look up and retrieve patient information to be prepared for a visit, and providers can send information to another provider or organization that a patient sees. Further, patients can view and download their own health information and share that information as they like. Foundational HIE is needed to ensure that providers have the information they need, to avoid delays in care, and to avoid duplicate tests or procedures.

Many health organizations in Minnesota can share information, but fragmentation doesn’t allow information to flow with the patient. The foundational HIE happening in Minnesota is driven largely by organizations that use the Epic EHR system, which has built-in HIE functionality among Epic users. More than half of Minnesota’s 146 hospitals and roughly 1,500 clinics use Epic, with a much larger percent of the population being served by these organizations. Further, most of the large health systems have connected to national HIE networks to support exchange of clinical health information. Exhibit 2 shows an example of the impact of these connections. While just 63% of hospitals and 38% of clinics in Minnesota indicated that their providers routinely have the necessary clinical information available electronically, Epic users have much more access to this information than non-Epic users. Minnesota’s health care market is expected to continue to be served by multiple EHR vendors because, at this time, a single vendor does not meet the varied needs of providers across the care continuum.
Robust HIE: Information is used to manage patient care

Robust HIE means that health organizations can use patient information from all providers across the care continuum to better understand the full health perspective of the person. This comprehensive view of the person allows the provider to offer complementary care, avoid counteractions in care, and more accurately monitor outcomes. Robust HIE can also support coordination across a wider range of health providers, such as an alert to engage social services when a person visits the emergency room frequently, so the source of the problem can be addressed in a timely manner. This support may need to come from a mental health provider or social services, so they can use HIE to alert and refer a patient. Robust HIE also supports “closed-loop” referrals so that a provider receives a report back when a patient has been referred.

The gaps in foundational HIE also translate to gaps in robust HIE. While many of Minnesota’s larger health systems use data from their EHR to actively manage patient care, the capacity to use information varies by health system. Few health systems have captured information from all the sources that may impact a person’s health, and fewer still are doing this electronically. Minnesota currently has several health information organizations (HIOs) that are connecting providers and offering robust HIE services across the care continuum. However, at this point less than 20% of Minnesota’s hospitals and clinics are currently or in the process of onboarding with an HIO. Local public health agencies are more aggressively engaging, with 24% of counties connected or onboarding.

Optimal HIE: Information is connected to support community health

Optimal HIE means that health data can be utilized to generate aggregated assessments of specific health issues, such as obesity rates by age and zip code, in order to identify disparities, target interventions, and implement prevention programs. This fills an important gap in information that is currently not available to communities. Without this information, they are not as equipped to target and optimize the effectiveness of programs and interventions to “move the needle” toward better health. Optimal HIE can also support community preparedness to manage incidents/disasters, epidemics, and
other public health crises by providing a mechanism to quickly assess injury and disease status in the affected area.

Optimal HIE is beginning to evolve in Minnesota and nationally. However, the concept is new and the opportunities are not currently understood by all stakeholders. Efforts have begun in Minnesota to use optimal HIE to address community health problems, but because of fragmented foundational and robust HIE, many efforts are currently manual processes or cumbersome electronic processes. We know anecdotally that investments by communities through Minnesota’s State Innovation Model\(^2\), have resulted in collaborations among local government organizations, payers, and others to use HIE in support of healthier communities.

**Stakeholder-identified HIE issues and gaps**

HIE is complex because there are many reasons to exchange information, a variety of ways to exchange information, and many relationships to build and sustain. Stakeholders interviewed for this study identified and acknowledged existing barriers and gaps, and shared ideas to develop a solution. Key overarching perspectives are that Minnesota needs to establish and communicate a statewide goal for HIE, develop a plan to achieve this goal, and address existing legal barriers that inhibit foundational and robust HIE. Specific issues and gaps include:

1. **The need to establish foundational HIE across all providers in the state** to minimize the potential risk to patients from our current status: errors, redundant tests/exposures, poor outcomes, excessive costs, and more. This includes providers other than clinics and hospitals (e.g., long-term and post-acute care, local public health, behavioral health, dentists, pharmacists, social services, etc.) to ensure that a person’s entire care team is connected. In terms of information sharing among clinics and hospitals, this challenge is especially notable for smaller, independent providers and for provider systems not using Epic as their EHR vendor.

2. **Many providers face barriers to HIE because of varied interpretations of the Minnesota Health Records Act** (MHRA), as well as some of the provisions of the act that are challenging to operationalize. This barrier was raised in almost all the interviews, and changes to MHRA were the most often cited suggestion from interviewees for the single, most impactful action Minnesota government could take to promote growth in and sustainability of HIE. This call for change is supported by the findings of MDH’s 2017 report to the legislature, “Impacts and Costs of the Minnesota Health Records Act.”\(^3\) These include:
   a. The MHRA does not adequately support the majority of patients whose preference, as reported by providers, is to share their health information to ensure they receive appropriate care.
   b. If the consent requirements of the MHRA remain in place, some clarifications to operationalize the current MHRA intentions are needed.
   c. Providers need education, resources and legal assistance related to the MHRA, especially providers in smaller practices. Education and resources are also needed by patients to understand their rights, how information is used, and security protections.

---


d. Implementing MHRA often requires a manual workaround process for obtaining patient consent outside of the EHR system digital workflow. This implies more resources are needed for implementation of customized systems that are MHRA-compliant.

e. It will be difficult for Minnesota to achieve its goals related to coordination of care for complex patients, improved quality of care, and cost savings due to varied interpretations of the consent requirements in the MHRA.

3. Most large health systems in Minnesota do not plan to participate in a State-Certified Health Information Organization in the near future. They have invested in EHR and data management systems to manage their own patient populations and, in many cases, to share clinical information with national networks and/or with other provider systems that use the same EHR system vendor. As such, they do not see value in the services offered by Minnesota’s certified HIOs. However, these connections do not support exchange with many of Minnesota’s hospitals and clinics that do not use Epic or are not connected to national networks. Because of this gap in foundational HIE these health systems likely do not know the whole breadth of providers a patient sees. This is particularly problematic for organizations that are engaged with accountable care payment contracts, as they cannot control the care or outcomes resulting from care provided outside of their organization.

4. Minnesota’s HIOs are not connected with one another. Each HIO has implemented a consent management system with a master patient index to allow providers to accurately identify a patient when the patient has provided consent. This infrastructure will support their ability to connect, but at this time there is no formal governance for them to connect.

5. Minnesota needs to develop a coordinated and sustainable approach for HIE. Minnesota does not have a governing body to make policy decisions and enforce rules of the road. To date Minnesota has taken a ‘limited government approach’ by facilitating discussions and consensus of state certified entities to move HIE forward, but this is effectively a volunteer effort.

6. Minnesota’s current HIE environment does not support a wellness-based approach to enable unhealthy people to get healthy, and healthy people to stay healthy. Health providers need robust HIE to use information to understand treatment outcomes and coordinate care, as well as to support accountable health. Stakeholders participating in Minnesota’s Integrated Health Partnerships (Medicaid accountable health) shared concerns about their ability to further improve outcomes and reduce costs without access to timely clinical data via foundational HIE.

7. The value that optimal HIE can offer to all stakeholders is not well recognized, but some stakeholders see potential for optimal HIE to make a difference in the health of their communities, particularly in rural Minnesota. Optimal HIE can support communities with aggregated, timely, information on the health of the population and geographic/demographic subpopulations. This type of information is sorely needed by Minnesota’s local health departments to create and monitor effective public health programs.

8. Many stakeholders struggle to efficiently transmit information, resulting in administrative “pain points” that require manual processes, which direct resources away from patient care. Example inefficiencies include: managing patient consent when organizations have varied interpretation of MHRA; precise patient matching to ensure the correct information is exchanged; accurate and up-to-date provider directories; and processes to efficiently conduct required reporting such as for
quality measures and public health. A coordinated HIE infrastructure can provide efficient ways to transmit these data, which could have significant cost-containment benefits for stakeholders and health care consumers.

9. **Stakeholders also identified cost containment benefits that a coordinated HIE infrastructure can support.** Examples include: avoiding duplicative tests and imaging, appointment delays and cancellations due to lack of information; workforce resources associated with manual data entry; cost of errors associated with manual entry; streamlined care transitions upon hospital discharge; and alerting for emergency department visits.

**Minnesota’s current HIE model**

Minnesota’s current HIE model recognizes two types of entities that provide the infrastructure for HIE. Those two entities, Health Information Organizations (HIO) and Health Data Intermediaries (HDI) are required to be certified under the state’s oversight program. An HIO is an organization that oversees, governs, and facilitates HIE among health care providers from unrelated health care organizations. An HDI is an entity that provides the technical capabilities, or related products and services, to enable HIE among health care providers from unrelated health care organizations (but doesn’t govern the information). There are currently four organizations certified as HIOs in Minnesota, and 17 certified as HDIs.⁴

Minnesota’s HIE oversight law requires HIOs to connect to all other HIOs, and HDIs to connect to at least one HIO. Health care providers are required to connect to an HIO, either directly or indirectly by connecting through an HDI that is connected to an HIO⁵. Exhibit 3 below portrays the connections expected between HIOs. This model requires many point-to-point connections for the HIOs to connect to each other, creating inefficiencies and duplication. There is no limit to the number of HIOs that may operate in Minnesota, so this model would increase in complexity if more HIOs entered the market. Furthermore, as previously noted, many of Minnesota’s large health systems, as well as provider organizations across the care continuum, are not connected to an HIO. As such, this model is both inefficient and ineffective.

The provider organizations that are not connected to an HIO, yet still engaging in HIE, are managing many point-to-point connections. Examples include: to one or more national networks; to other health systems, particularly those not connected to a national network; Minnesota Department of Health; and health plans/payers. These varied connections are also inefficient and direct resources away from patient care.

---

⁴ A list of Minnesota’s certified HIE service providers is at: [http://www.health.state.mn.us/e-health/hie/certified/index.html](http://www.health.state.mn.us/e-health/hie/certified/index.html)

⁵ This is a requirement of the Minnesota Interoperable EHR Mandate, which does not have an enforcement provision. Information is at: [http://www.health.state.mn.us/e-health/hitimp/index.html](http://www.health.state.mn.us/e-health/hitimp/index.html)
Exhibit 3: Minnesota’s Current HIE Model – Inefficient Network Connections

As a result of these inefficient and incomplete connections, Minnesota’s health organizations are stuck managing multiple point-to-point connections, and/or relying on manual workarounds. Some large health systems, however, have been able to establish mechanisms for HIE outside of Minnesota’s infrastructure of HIOs and HDIs, usually by relying on the capabilities of Epic and national networks. Exhibit 4 below depicts how a large health system using Epic might manage their information exchange needs. This shows that the health system has reasonably seamless connections to other Epic users and national networks (green) for sharing at least some types of information, but multiple other connections to meet the scope of their needs (yellow), and potentially no connections to non-clinical providers (orange).
A Proposed Solution

While there are many gaps in HIE capabilities across Minnesota providers and communities, there are also many key assets to build upon. One of the key needs is to enhance Minnesota’s HIE infrastructure using a more coordinated approach to:

- Reduce fragmented care and potential harm to patients by offering a core set of coordinated services that support foundational HIE.
- Support care coordination for people with many/complex needs that extend beyond clinics and hospitals.
- Allow appropriate use of information to improve individual outcomes and support population and community health.
- Increase administrative efficiencies for stakeholders, so resources can more effectively support patient care.
- Build on the successes of current HIE activities and networks.
- Prepare for future changes in technologies, markets, policies, and public emergencies.

Connected networks model

The proposed “connected networks” model will close gaps in Minnesota’s foundational HIE and build the infrastructure for robust and optimal HIE that provides value to stakeholders. This model involves establishing an entity to develop and manage high-value coordinated services, to which the various networks all connect either directly or through an HIO. Examples of these services include a common provider directory, a master patient index, and a system for managing patient consent preferences.
Exhibit 5 shows how networks would connect to each other via centralized coordinated services under the proposed approach. Key differences from Minnesota’s current HIE approach include:

- Provider organizations would have the option to connect either by using an HIO (consistent with the current model) or directly (the proposed option).
- Provider organizations that connect directly would need to have HIO-like capabilities (e.g., HIE capabilities, data normalization and management).
- A common set of governance expectations would be established, including data sharing requirements and an ongoing governance process.
- The number of connections between networks would be streamlined whenever possible.

**Exhibit 5: Proposed “Connected Networks” Model Visualization**

**Coordinated HIE services**

At the core of the Connected Networks model would be a set of coordinated or shared services and common governance rules to support operational and administrative efficiencies and better coordinated care. Potential coordinated HIE services include:

- Master patient index to support trust that the match of patient to patient information is correct.
- Consent management and rules to ensure that a patient’s preferences are commonly understood by all providers.
- Alerting for acute care events, such as emergency department visits, to inform the primary care team of the event and provide them with the opportunity to participate with the situation if needed.
- Provider directory to ensure that provider information and credentialing is current and correct.
- Medication history, including prescription monitoring program information, efficiently integrated into the workflow and decision support tools.
- Streamlined reporting for state and federal requirements (e.g., quality measures, public health data).
Value proposition

This model is expected to provide value to all connected stakeholders with services that improve patient care and reduce inefficiencies. Value propositions for stakeholders include:

- Patients benefit because their information is easily available to any provider whom they want to have it, they don’t need to repeat their health history with each appointment, and don’t need to endure redundant tests and imaging.
- Information flows with the patient, meaning that care providers are prepared for appointments and trust that they have the correct information, and can see a person’s whole health perspective and not just clinical and/or acute care.
- Providers have meaningful information to support the care they provide. This includes more complete information for clinical decision support, better tools for care transitions and care coordination, and better understanding of patient outcomes.
- Health systems and health plans/payers have information to optimize patient safety, participate effectively in accountable health purchasing arrangements, and efficiently manage operational and administrative functions such as patient matching, consent management, provider directories, and required reporting.
- Communities and government have useful and actionable information on the health of the population, and infrastructure to support targeted response to public emergencies.

The Connected Networks model builds upon past efforts and takes advantage of many e-health assets already in existence in Minnesota. Minnesota is well-poised to succeed with this model because we have made significant e-health investments and have learned many lessons from previous attempts at establishing and connecting HIE networks. We also have a history of strong collaboration on e-health issues, including cross-sector collaborations accelerated due to recent accountable health efforts by provider organizations and communities across the state.

As a result of the study, there is a better understanding of what is needed to succeed. Key success factors include:

- A formal governance process, inclusive of all stakeholders, to make decisions, establish rules of the road, and provide agile management.
- Champions to embrace the “Optimal HIE” goal, endorse the model, and develop a plan to implement the model.
- Collaboration to implement the model, address issues, and contribute to the evolution of the model.
- Broad, if not complete, stakeholder participation to ensure long-term sustainability.
- HIE services that encourage participation and provide ongoing value.
Preliminary Recommendations

These preliminary recommendations have been developed in collaboration with multiple stakeholders. The HIE Study Steering Team (see Appendix B) and the Minnesota e-Health Advisory Committee\(^6\) have reviewed these recommendations and approved them to move forward for public comment. Below are two sets of recommendations, including recommendations that could be implemented without additional legislative authority and recommendations that will require additional legislative action.

Because of the complexity of this topic and unknown support for the Connected Networks model, the Steering Team recommended (and the Advisory Committee endorsed) that these recommendations be initially applied to the context of Minnesota’s opioid misuse abuse and epidemic. Governor Dayton has requested the Advisory Committee to provide recommendations for using e-health to address this topic (independent of this study), and stakeholders across the state are urgently addressing it. HIE services provide the potential to support integration of comprehensive information a provider needs to appropriately prescribe controlled substances and address addiction treatment, using an infrastructure that is not limited to this epidemic. The preliminary recommendations below reflect that perspective, but with an understanding that implementation of the Connected Networks model would allow Minnesota to be able to address new priority use cases as they become identified through an established governance process.

Recommendations that can be implemented without legislative action

1. Establish a task force, reporting to the Minnesota e-Health Advisory Committee, to develop a business plan for and establish the “connected networks” model with an initial focus on addressing the opioid epidemic use case. At a minimum, the task force will address how to:
   a. Connect existing HIOs to each other.
   b. Establish foundational flow of patient information to support transitions of care (e.g., long-term and post-acute care, mental health providers, dentists, pharmacists, and others).
   c. Engage Minnesota’s health stakeholders around the opioid misuse and abuse epidemic to identify the HIE services needed to address this use case and to provide additional stakeholder value.
   d. Determine options for incorporating the Department of Human Services’ event alerting system (beginning implementation in fall 2017) into a statewide HIE approach, scalable to the total population.
   e. Assess market acceptance of the connected networks model based on their participation in the opioid epidemic use case.
   f. Develop an approach for initial and long-term funding that is sustainable, shared across organizations using and benefitting from the coordinated services.

Appendix C includes a more comprehensive list of factors that the task force will need to address. Participants in the task force will need to commit time and resources from their organization to support the responsibilities described in this recommendation.

\(^6\) Information is available at: [http://www.health.state.mn.us/e-health/advcommittee/docs/members.pdf](http://www.health.state.mn.us/e-health/advcommittee/docs/members.pdf).
Recommendations requiring legislation

2. Support legislation that will enable use of information for robust, value-added HIE services in compliance with patient consent and preferences. Modify the MN Health Records Act to better align with HIPAA and standardize understanding and implementation of consent across all stakeholders, without creating new unintended consequences. Appendix D provides options to consider.

3. Update Minnesota’s Health Information Exchange Oversight law (Minnesota Statutes §§ 62J.498 through 62J.4982) to support the coordinated networks model, specifically relating to the roles of Health Information Organizations and Health Data Intermediaries.

Considerations for implementation of this recommendation include evaluating updates to:

- Adopt a simplified registration process for marketing HIE technology capabilities in MN that aligns with the most recent Certified EHR Technology standards established by CMS and the Office of the National Coordinator for Health Information Technology (ONC).
- Simplify Health Data Intermediary (HDI) registration and process for vendor disclosure of services and ensuring understanding of Minnesota laws. Health Information Organization (HIO) certification will still be required.
- Expand HIO certification to include another level of requirements for systems choosing to connect to the network directly to coordinated services rather than connecting via an HIO.
- Enable a mechanism for stakeholders to report misconduct.

4. Appropriate funds to leverage matching federal/other funding opportunities to support the infrastructure development of the coordinated services. Cost estimates will be developed by the proposed task force.
Appendix A: Questions for Public Comment

A. Request for overall comments

Please provide any overall comments on the HIE study findings, proposal, and recommendations. Comments may include support, concern, and/or considerations that should be taken into account should the recommendations move forward to implementation. To the extent possible, organizational letters or statements of support are encouraged to better gauge the level of support by stakeholders in Minnesota.

B. Request for specific comments on the proposed “connected networks” model

1. To what extent do you view this “connected networks” model as heading in the right direction for Minnesota? What suggestions can you offer that would strengthen the concept? If you have concerns, what viable alternatives would you suggest?

2. Thinking about your organization (provide specific examples):
   a. What gaps does this concept address?
   b. Which coordinated HIE services would be valuable for your organization? Which of these are a higher priority for your organization?
   c. What downsides and/or unintended consequences do you see?

C. Request for specific comments on Recommendation 1: Convene a task force to develop a detailed plan to implement the “connected networks” model

1. What organization(s) should be involved in leading this effort? What ideas or recommendations do you have to actualize this task force? For example, what existing models could we build this from?

2. What would you and/or your organization commit in order to develop a plan to implement the recommended “connected networks” model? Examples include resources, expertise, leadership, logistic support, and staffing.

D. Request for specific comments on Recommendation 2: Modify the Minnesota Health Records Act

1. Indicate which, if any, option you and/or your organization would support.

2. What benefits and/or unintended consequences of any of these options do you foresee for your organization or generally? (specify the option, provide specific examples when possible)
Appendix B: HIE Study Project Team and Steering Team

Project team

Minnesota Department of Health

- Karen Soderberg, project lead
- Jennifer Fritz
- Marty LaVenture
- Shirley Schoening Scheuler
- Anne Schloegel
- Melinda Hanson
- Bob Johnson

Minnesota Management Analysis and Development

- Matt Kane
- Jim Jarvis

Minnesota Department of Administration

- Stacie Christensen
- Taya Moxley-Goldsmith

Steering team

- Alan Abramson, HealthPartners
- Julia Adler-Milstein, University of California – San Francisco
- Todd Bergstrom, Care Providers of Minnesota
- Laurie Beyer-Kropuenske, Minnesota Department of Administration
- Garrett Black, Blue Cross Blue Shield of Minnesota
- Brian Dixon, Riegenstrief Institute
- Dan Jensen, Olmsted County
- Jennifer Lundblad, Stratis Health
- Deanna Mills, FUHN
- Heather Petermann, Minnesota Department of Human Services
- Diane Rydrych, Minnesota Department of Health
- Mark Sonneborn, Minnesota Hospital Association
- Joshua Vest, Indiana University
- Donna Watz, Minnesota Department of Commerce
Appendix C: Recommendation #1, Task Force Detailed Plan Topics

The task force will need to propose a solution that addresses:

1. Governance
   a. Identify coordinated services, including priorities and a framework for adding future services.
   b. Determine how to operate coordinated services in a way that is adaptable to emerging HIE needs and opportunities.
   c. Develop the requirements and processes to support health systems and other HIE networks to connect directly to coordinated services, including networks in border states.
   d. Establish necessary requirements for membership (e.g., trust framework agreement, commitment to contribute data, commitment to offer agreed upon HIE services, commitment to redistribute data if leaving the network/market).
   e. Determine the appropriate information that should be available to stakeholders, including health plans and government.
   f. Conduct a data requirements assessment among all stakeholder types as part of short and long-range planning and services development.

2. Finance
   a. Estimate costs for establishing services and ongoing sustainability.
   b. Examine and recommend finance models and funding opportunities to support coordinated HIE services, including grant.
   c. Consider policy and other incentives to ensure participation.

3. Operations
   a. Develop a plan for continued operation, including plans for a type of organization to operate the services and continue managing governance and financing.
   b. Oversee HIE participation and compliance with rules.
   c. Establish and support an evaluation and assessment component of the network to document and identify improved efficiencies through streamlining workflow, workforce utilization, and value-added services.
   d. Establish and support a public communication/engagement plan to advance understanding of HIE, patient rights, and HIPAA protections.

The entity/task force is expected to collaborate with and build upon complementary HIE-related efforts in the state and region, including but not limited to: activities and evolution of HIOs and networks in Minnesota and nationally, implementation of the event alerting system (EAS) established by the Department of Human Services, and cross-sector efforts to support education, corrections, law enforcement, and other stakeholders.
Appendix D: Assessment of the Consent Requirements in the Minnesota Health Records Act and Menu of Options

Background

Historical feedback from both health care providers and patients in Minnesota often encompasses the tension, confusion and misunderstanding of the consent requirements in the Minnesota Health Records Act (MHRA) and how Minnesota’s consent law works with the federal regulations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") related to appropriate disclosure of health information. HIPAA’s “Privacy Rule” requires written patient authorization for certain disclosures of protected health information (PHI) but it does not require authorization when the disclosure is for the patient’s treatment, for payment for that treatment, or for health care operations purposes. In contrast, the MHRA requires written patient consent when a health care provider discloses an individual’s health records for treatment, payment, or health care operations and for most other releases, with limited exceptions.

The e-Health Advisory Committee’s Privacy and Security Workgroup has discussed this tension between state and federal law for over a decade and has worked to develop guidance and educational materials for patients and providers. In terms of compliance resources, the Privacy and Security Workgroup’s approach has always been to promote better understanding and more consistent implementation by all types of providers – both large and small.

In 2016, the Minnesota Legislature directed the Minnesota Department of Health (MDH) to provide a report after seeking public input on the consent requirements in the MHRA. The report confirmed much of the historical feedback related to the consent requirements in the MHRA. The report’s conclusions highlighted that the MHRA does not adequately support the majority of patients whose preference, as reported by providers, is to share their health information with their providers, and the report noted the need for some clarifications to operationalize the current MHRA intentions. In addition, the report stated that it will be difficult for Minnesota to achieve its goals related to coordination of care for complex patients, improved quality of care, and cost savings due to varied interpretations of the consent requirements in the MHRA.

Menu of Options

The Privacy and Security Workgroup discussed two primary options, related to disclosure of PHI by providers, for the Legislature to consider in promoting more effective and efficient HIE in Minnesota. Under both proposed options, some additional disclosures could happen without written consent from the patient. However, HIPAA would still require a covered entity to disclose only the minimum necessary PHI to accomplish the intended disclosure and permit an individual to request restrictions on those disclosures of PHI for purposes of treatment, payment or health care operations.

Following two meetings of the Minnesota e-Health Initiative’s Privacy and Security Workgroup, there was not consensus among the members in recommending a single approach. Certain members of the
Workgroup identified that an incremental approach to changing the MHRA, in an attempt to eliminate confusion and inconsistency, would be beneficial while other members indicated that an incremental approach would only cause further confusion and said full implementation in aligning the MHRA with HIPAA is necessary. There was general consensus that a consistent approach for all providers (covered entity or not) would be the most beneficial and in keeping with Minnesota’s privacy traditions. Most workgroup members favored Option 2, Alternative C3 (partial alignment for purposes of treatment, payment and health care operations). There was also some support for Option 1, alternative A (full MN alignment with HIPAA for current covered entities).

Summary descriptions of options and alternatives are described below. Example legislative language for both options is at: [http://www.health.state.mn.us/e-health/hie/study/index.html](http://www.health.state.mn.us/e-health/hie/study/index.html).

**Option #1: Fully align Minnesota law with HIPAA**

**Considerations for Option #1**
- Full alignment with HIPAA removes many actual or perceived barriers for HIE in MN.
- Under HIPAA, disclosures have rules/requirements. HIPAA is not simply “the absence of consent.”
- MHRA continues to have a private right of action under section 144.298, which applies even in situations where consent is not required.
- The Minnesota Attorney General can already enforce HIPAA.
- Updates definitions to align with HIPAA.
- Provides that written consent is not required for disclosures for purposes of treatment, payment, or health care operations and other permitted or required disclosures.
- Eliminates duration and exceptions to consent requirements.
- Eliminates opt-out language related to record locator/patient information service.
- Aligns documentation, warranty, disclosure to law enforcement, and research requirements with HIPAA.
- Aligns relevant insurance provisions with HIPAA.
- Aligns relevant provisions in the Data Practices Act with HIPAA.

**Option #1, Alternatives A-B**

A. **“Strike MHRA for HIPAA covered entities and replace with HIPAA.”** Fully repeal MHRA (Minn. Stat. 144.291-144.298) and insert basic language stating that HIPAA governs the disclosure of PHI for providers that are HIPAA covered entities. [State examples: Hawaii (https://www.lawserver.com/law/state/hawaii/hi-statutes/hawaii_statutes_chapter_323b) and Kansas http://media.khi.org/news/documents/2012/10/10/khite-2011.pdf]

**Considerations for Option #1, Alternative A**
- Takes a straightforward approach for HIPAA covered entities; may be less confusing and easier to implement than an incremental approach.
- Minnesota health care providers that are currently not HIPAA covered entities must still comply with MHRA which leaves a disparate result. Such entities include small providers, school-based care, and other settings where care providers do not bill payers.
- Removes certain privacy protections for MN patients, especially related to sensitive information such as mental health, HIV/STD, and genetic information.
B. **Revise Minnesota Health Records Act (MHRA) for all providers to fully align with HIPAA for disclosure of PHI by providers.**

The basic MHRA framework stays in place, but all providers follow the HIPAA rules regarding disclosure of PHI, irrespective of whether they are covered entities under HIPAA.

**Considerations for Option #1, Alternative B**

- Could be easier to implement than partial alignment; it offers a consistent approach for all providers (covered entity or not).
- Might not be workable and could be extremely burdensome to make current non-covered entity providers broadly liable for compliance with HIPAA – for security, breach reporting, for example.
- Removes certain privacy protections for MN patients, especially related to sensitive information such as mental health, HIV/STD, and genetic information.
- Could result in potential unintended consequences in revising MHRA to incorporate HIPAA language (e.g. definitions may not properly align, etc.) and revising the MHRA has the potential to be done incorrectly and cause greater confusion.

**Option #2: Partially align Minnesota law with HIPAA**

This option maintains all patient rights currently in the MHRA but allows disclosures by providers without patient consent for the limited basis of treatment and/or payment and/or health care operations (depending on the alternative approach A, B, or C – described below). It also includes optional language to align MN law with permissible disclosures to friends and family involved in a patient’s care and to law enforcement, as currently permitted in HIPAA.

**Considerations for Option #2**

- An incremental approach may be more palatable than full alignment with HIPAA.
- There may be potential unintended consequences in revising MHRA to incorporate HIPAA language.
- Under HIPAA, disclosures have rules/requirements. HIPAA is not simply “the absence of consent.”
- MHRA continues to have a private right of action under section 144.298, which applies even in situations where consent is not required.
- The Minnesota Attorney General can already enforce HIPAA.
- This approach removes certain patient controls for MN patients, especially related to sensitive information such as mental health, HIV/STD, and genetic information.
- Revising the MHRA incrementally has the potential to be done incorrectly and cause greater confusion.
- Updates certain definitions to align with HIPAA.
- Allows disclosures for care coordination activities and to friends/family and law enforcement in compliance with HIPAA.
- Repeals certain consent requirements as no longer applicable (duration, expiration).
- Partially aligns opt-out language related to record locator/patient information service.
- Aligns relevant insurance provisions with HIPAA.
- Aligns relevant provisions in the Data Practices Act with HIPAA.
Option #2, Alternatives A-C

A. Amend MHRA to partially align with HIPAA for only treatment purposes.

Considerations – specific to Option 2, Alternative A (alignment with HIPAA for “treatment”)
- Allowing providers to disclose without MHRA consent for purposes of treatment only is a positive incremental approach to removing certain barriers in the MHRA.
- This incremental approach may not fully address efficient and effective HIE (e.g. continued barriers when disclosing for purposes of payment related to treatment and care coordination).

B. Amend MHRA to partially align with HIPAA for treatment and payment purposes.

Considerations – specific to Option 2, Alternative B (alignment with HIPAA for “treatment and payment”)
- Allowing providers to disclose PHI without MHRA consent for purposes of treatment and payment only is a positive incremental approach to removing certain barriers in the MHRA.
- This incremental approach may not fully address efficient and effective HIE (e.g. continued barriers when disclosing for purposes of care coordination between certain providers).

C. Amend MHRA to partially align with HIPAA for treatment, payment, and health care operations purposes.

Considerations – specific to Option 2, Alternative C (alignment with HIPAA for “treatment, payment, and health care operations”)
- Allowing providers to disclose without MHRA consent for purposes of treatment, payment, and health care operations is a positive incremental approach to removing a majority of barriers in the MHRA.
- This approach may raise privacy concerns because of the broad scope of health care operations.
MHRA Menu of Options: When is MHRA consent required?

The Minnesota Health Records Act (MHRA) currently requires consent for most disclosures outside of a “related health care entity.” This chart summarizes when MHRA consent is required for disclosures under current MN law and how that might change with proposed options to amend current law. All disclosures remain subject to the specific processes and limitations currently in HIPAA related to the type of disclosure. While some disclosures are permitted under HIPAA without written consent or authorization, covered entities must always make reasonable efforts to limit protected health information (PHI) to the minimum necessary to accomplish the intended disclosure and must comply with certain opt out and notice requirements.

<table>
<thead>
<tr>
<th>Disclosures</th>
<th>MHRA (current law)</th>
<th>Option 1, Alt. A &amp; B: Full HIPAA alignment with MHRA</th>
<th>Option 2, Alt. A: Partial HIPAA alignment, Treatment (T) only &amp; certain disclosures</th>
<th>Option 2, Alt. B: Partial – Treatment (T) &amp; payment (P) only and certain disclosures</th>
<th>Option 2, Alt. C: Partial – Treatment (T), payment (P), or health care operations (O) &amp; certain disclosures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider to patient</td>
<td>Must disclose</td>
<td>Must disclose</td>
<td>Must disclose</td>
<td>Must disclose</td>
<td>Must disclose</td>
</tr>
<tr>
<td>Provider to provider</td>
<td>Disclose only with MHRA consent</td>
<td>MHRA consent not required; HIPAA limits disclosures</td>
<td>MHRA consent not required for T; HIPAA limits disclosures</td>
<td>MHRA consent not required for T or P; HIPAA limits disclosures</td>
<td>MHRA consent not required for TPO; HIPAA limits disclosures</td>
</tr>
<tr>
<td>Provider to payer</td>
<td>Disclose only with MHRA consent</td>
<td>MHRA consent not required; HIPAA limits disclosures</td>
<td>Disclose only with MHRA consent; HIPAA limits disclosures</td>
<td>MHRA consent not required for T or P; HIPAA limits disclosures</td>
<td>MHRA consent not required for TPO; HIPAA limits disclosures</td>
</tr>
<tr>
<td>Provider to friends and family</td>
<td>Disclose only with MHRA consent</td>
<td>MHRA consent not required; HIPAA limits disclosures</td>
<td>MHRA consent not required for T; HIPAA limits disclosures</td>
<td>MHRA consent not required for T or P; HIPAA limits disclosures</td>
<td>MHRA consent not required; HIPAA limits disclosures</td>
</tr>
<tr>
<td>Provider to law enforcement</td>
<td>Disclose only with MHRA consent*</td>
<td>MHRA consent not always required; HIPAA limits disclosures</td>
<td>MHRA consent not always required; HIPAA limits disclosures</td>
<td>MHRA consent not always required; HIPAA limits disclosures</td>
<td>MHRA consent not always required; HIPAA limits disclosures</td>
</tr>
<tr>
<td>Provider to researcher</td>
<td>Disclose only with MHRA consent</td>
<td>MHRA consent not always required; HIPAA limits disclosures</td>
<td>MHRA consent required; HIPAA also limits disclosures</td>
<td>MHRA consent required; HIPAA also limits disclosures</td>
<td>MHRA consent required; HIPAA also limits disclosures</td>
</tr>
<tr>
<td>By provider in an emergency</td>
<td>MHRA consent not required</td>
<td>MHRA consent not required; HIPAA also limits disclosures</td>
<td>MHRA consent not required; HIPAA also limits disclosures</td>
<td>MHRA consent not required; HIPAA also limits disclosures</td>
<td>MHRA consent not required; HIPAA also limits disclosures</td>
</tr>
</tbody>
</table>

*MHRA allows for some disclosures without consent to law enforcement relating to mental health.

**HIPAA authorization is more stringent than consent under the MHRA, with specific legal requirements.

NOTE: HIPAA requires a covered entity to permit an individual to request restrictions on uses or disclosures of PHI about the individual to carry out treatment, payment, or health care operations (TPO). The covered entity is not required to agree to a restriction. Additionally, nothing in HIPAA prevents a covered entity from requesting consent from an individual for disclosures to carry out TPO.