## MN HIE Study Public Comment Responses

**November 3, 2017**

### Organizational responses

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October 31, 2017

Attn: HIE Study Project Team
Minnesota Department of Health
P.O. Box 64882
St. Paul, MN 55164-0882

Submitted electronically to MN.eHealth@state.mn.us

RE: HIE Study Comments

To the members of the HIE Project Team:

On behalf of Allina Health, we appreciate the opportunity to provide comments on the proposed recommendations to improve Health Information Exchange in Minnesota.

As a not-for-profit health care system, Allina Health is dedicated to the prevention and treatment of illness and enhancing the greater health of individuals, families and communities throughout Minnesota and western Wisconsin. Allina Health cares for patients from beginning to end-of-life through its 90+ clinics, 12 hospitals (urban tertiary care and community hospitals), 16 retail pharmacies, specialty care centers and specialty medical services that provide home and hospice care, EMS, and other vital services. In addition to our full continuum of services, we are also one of four certified Health Information Organizations (HIO) in the state.

Connected Networks
We appreciate that the HIE Project Team identified the challenges with adopting a more centralized services model, whereby a single entity would connect all partners. That having been said, significant challenges also exist with a connected networks model. In particular, a connected networks model can only be successful if providers are able to fully utilize the capabilities of an electronic medical record.

In its final recommendations, the Project Team and its partners should consider whether to require that each Technology vendor providing services in the state of Minnesota implement a connection with CareQuality, CommonWell, or another national framework that includes governance, technical specifications, and legal agreements.

The connection to a national framework that is customized to Minnesota’s unique needs is vital to successful HIE because though the current focus of CareQuality is a query/response transaction of continuity of care documents, optimizing a national framework could be leveraged to expand to other transactions and data sets for additional use cases in the future such as ADT alerts, PMP, public health
reporting, etc. This national framework could also incorporate unified patient matching standards and require each participant to use those standards for accurate patient matching.

We would also encourage the Project Team to consider revising its recommendations to include collaborating with EMR vendors operating in the state to:

- Offer an automated query option for identifying locations to where a patient has another electronic record, and
- Include narrative content capabilities in the form of Progress Notes, History and Physical Examination, Discharge Summary, Operative Reports, and Continuity of Care Document. At present, most vendors only include the 17 mandatory data sets CMS requires for certified EHR Technology.

**Task Force Recommendations**

Allina Health supports the general recommendation to establish a task force and charge it with the responsibility of designing a connected networks implementation plan. That having been said, we firmly believe that the scope of this task force should be narrower and more focused than the described responsibilities in the draft recommendation. Adding another layer of complexity by creating a Coordinated Services model to the already confusing landscape of HIE in Minnesota could frustrate the provider community even more. Therefore, we would charge a Task Force with a primary objective to address the current state capabilities and limitations of providers and the electronic medical record systems used by each respective entity.

With that more focused approach in mind, we would offer the following sub-recommendations:

- The Task Force should accurately identify the varied use cases which require data exchange because there will not be a single solution that meets the needs for all use cases. In terms of methodology, we would recommend that any use case is also tested for increased permeation throughout all Minnesota providers.
- MDH, in consultation with the Task Force, should establish and maintain a database of providers and facilities, cross-referenced with their EMR technology, HIO/HDI connection, and HISP Provider. We would further encourage MDH to provide annual updates to this database.
- The Task Force and state agency partners should identify ways to streamline the number of different connections required for providers and other community partners to submit information to the State. At present, there are nearly two dozen state programs that require data from providers, the majority of which use different platforms for receiving information.

In order to improve the likelihood of success, we recommend that a Task Force be required to include membership from all of the certified CIOs, the national framework entity like CareQuality, and at least two certified Health Data Intermediaries (HDI). We are concerned that pursuing a connected networks model will place a disproportionate amount of burden and organizational resource on those entities in particular. As a result, any successful planning and network construction will be incumbent upon
meaningful engagement among the key partners, as well as a sincere commitment to sustained issues management.

**Modifications to the Minnesota Health Records Act**

With respect to improving patient experience, quality and cost, Allina Health strongly supports the recommendation to align the Minnesota Health Records Act to the Health Information Portability and Accountability Act (HIPAA). In responding to the draft HIE study report specifically, we believe that this statutory change is critical to the success of health information exchange.

Allina Health would endorse Option 1, as described by the draft recommendations, however, it is our view that the objective may be accomplished with fewer statutory changes than those set forth in either Alternative A or B. We would welcome an opportunity to discuss alternate language with members of the HIE Project Team, MDH, and others if there is interest. In addition to the draft recommendations for Alternative 1, we would encourage the Project Team to include a recommendation to align the definition of “Health Record” as defined under the MHRA, with the definition of “Protected Health Information” as defined under HIPAA for consistency.

Finally, we are supportive of the modifications to the Record Locator Service and Patient Locator Service consent proposed under Alternative B (Minn. Stat 144.293 Subd. 8), and would further support an additional modification to delete subsection (d) in its entirety as opposed to amending “must” to “may”.

Again, on behalf of Allina Health, we sincerely thank the HIE Project Team, e-Health Advisory Committee, and all of their partners in providing this comprehensive assessment on Health Information Exchange in our state. We welcome the opportunity to collaborate with you on moving these recommendations forward.

Sincerely,

Careen Martin, JD

Vice President; Chief Privacy Officer

Allina Health

612-262-4899 • careen.martin@allina.com
Dear Ms. Soderberg and Committee members:
As a professional organization of primary care and subspecialty internists, with more than 2400 members in Minnesota, the Minnesota chapter of the American College of Physicians, has a high degree of interest in the proposed Health Information Exchange.

Comments from our HIT Committee on the Oct. 2, 2017 Minnesota Health Information Exchange Legislative Study Request for Public Comment are noted below.

A. Request for overall comments
The MN Chapter of the American College of Physicians (MN-ACP) strongly supports the concept to link all MN hospitals, Clinics and other health care provider organizations under one HIE (Health Information Exchange). The National ACP HIT (Health Information Technology) committee is in agreement with the ONC’s Health IT strategic plan which has a strong focus on connectivity and HIE at state and national level. This proposal will align the state ACP HIT goals with the national ACP goals.

B. Request for specific comments on the proposed “connected networks” model
The American College of Physicians is an advocate for doing what is right for the patient, this proposal would help patient information to flow between organizations irrespective of EHR barriers in a seamless manner thus helping providers make decisions in a timely and efficient manner. It would also reduce the total cost of care by avoiding duplicating tests and easing the participation in cost sharing measures through Accountable Care Organizations which are now often set up across care systems.
This model would also give providers access to other places patients often are cared for such as Nursing Homes, standalone Urgent Care and Emergency rooms as well as community Clinics.

C. Request for specific comments on Recommendation 1: Convene a task force to develop a detailed plan to implement the “connected networks” model
All major health systems in MN should have representation on the task force, additionally the MN Chapter of ACP would like to be represented as well by inclusion of the chair of the MN ACP Health IT Chairperson or an appointed representative as a member of the task force.

D. Request for specific comments on Recommendation 2: Modify the Minnesota Health Records Act
MN ACP would support Option 1 Alternative B, this would be in keeping with the principals laid down by the National ACP IT governance. This option would offer a consistent approach for all providers irrespective of if they are covered entities or not.

If you have questions or need further information, please contact me at Minnesota.ACP@gmail.com or phone 651-492-1994.

Very truly yours,

John Bundrick, MD, FACP
Governor, Minnesota Chapter of the American College of Physicians

Deepthi Pandita, MBBS, FACP
Chair of the MN-ACP HIT Committee
October 31, 2017

Dr. Edward Ehlinger
Commissioner of Health
Minnesota Department of Health
625 Robert St. N
PO Box 64975
St. Paul, MN 55164-0975

Dear Commissioner Ehlinger:

Audacious Inquiry (Ai) is a health information technology (health IT) and policy firm that has earned a reputation for its nationally respected experts, industry-shaping technology, and unparalleled accountability. Ai’s current customer base includes healthcare policy organizations; health information organizations (HIOs); provider organizations; healthcare associations; state and federal agencies; and private payer organizations. Ai has deep experience in the interoperability space, both with building and maintaining health IT infrastructure to support interoperability for a number of HIOs and providing subject matter expertise to the Office of the National Coordinator for Health IT (ONC) on interoperability matters. Ai appreciates the opportunity to provide comments on the Minnesota Health Information Exchange Legislative Study (HIE Study).

We acknowledge the time and effort the Minnesota Department of Health (MDH), the HIE Study Steering Team, and the Minnesota e-Health Advisory put into developing this thoughtful study outlining an approach to accelerate health information exchange (HIE) in the state and create a more coordinated approach to HIE infrastructure. Ai offers the following comments as a means to provide a possible view of how the Minnesota Department of Human Services (DHS) encounter alert service (EAS) implementation could be used to help support HIE services in MN, the study specifically acknowledges it would like to “determine options for incorporating DHS’ EAS into a statewide HIE approach, scalable to the total population.”

We have found notification services can be implemented broadly and quickly based on the infrastructure components and basic HL7 ADT feeds necessary to power the solution. This solution can provide value to a range of stakeholders including providers, payers, and public health. A notification service, such as EAS, can provide a needed boost to support the more difficult work of establishing a query-based service that is used by providers on a regular basis. As such, the Minnesota Department of Human Services selected Ai to provide an encounter alert service for Medical Assistance beneficiaries starting with those receiving
services through Integrated Health Partnerships (IHPs). DHS and Ai are currently working to implement EAS with at least two IHPs by the end of December 2017 with all IHPs implemented and sharing ADTs by December 2019.

The DHS EAS approach recognizes the challenges associated with prior query models and positions Minnesota for success by laying foundational infrastructure with high value notification use cases. This is a sound approach that we know works due to our experience working with the Florida Health Information Exchange, as one example. Table 1 below details the ways that MN can leverage the work already underway through the DHS EAS implementation.

Table 1: Gaps and EAS Alignment

<table>
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<th>Stakeholder-identified HIE issues and gaps</th>
<th>How DHS EAS may be able to help</th>
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<tr>
<td>1</td>
<td>The need to establish foundational HIE across all providers in the state</td>
<td>EAS includes several statewide foundational components:</td>
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<td></td>
<td></td>
<td>Technical: MPI, Patient-to-Provider Relationships directory (all can be queried via APIs).</td>
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<tr>
<td>2</td>
<td>Many providers face barriers to HIE because of varied interpretations of the Minnesota Health Records Act (HRA)</td>
<td>EAS includes Participation Agreement and Policies which address the nuances of the MN HRA for specific data uses and use cases.</td>
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<tr>
<td>3</td>
<td>Most large health systems in Minnesota do not plan to participate in a State-Certified Health Information Organization in the near future.</td>
<td>EAS is targeting all health systems, starting with those participating with the DHS IHP initiative.</td>
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<td>4</td>
<td>Minnesota’s HIOs are not connected with one another.</td>
<td>EAS can connect to all HIOs (as driven by IHP connectivity).</td>
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<td>5</td>
<td>Minnesota needs to develop a coordinated and sustainable approach for HIE.</td>
<td>EAS has a sustainability model which has proven successful in other states to fund some of the basic HIE infrastructure (see #1).</td>
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<td>6</td>
<td>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.</td>
<td>EAS can send alerts regarding ADT events to a patient’s PCP and care coordinator that includes patient diagnosis, acuity level, and other clinically relevant. The clinical care team can use this information to intervene promptly to provide needed resources to high risk patients and steer inappropriate utilizers to appropriate levels of care.</td>
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<td>7</td>
<td>The value that optimal HIE can offer to all stakeholders is not well recognized,</td>
<td>EAS has proven to provide value in other states. Specifically, regarding Readmission reduction and Transitional Care Management. There have also been Provider and Patient satisfaction benefits.</td>
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<td>8</td>
<td>Many stakeholders struggle to efficiently transmit information</td>
<td>EAS is based on HL7 ADT messages, which are very simple to implement. Alerts are sent in a range of formats, based on use cases and subscriber preference.</td>
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<td>9</td>
<td>Stakeholders also identified cost containment benefits that a coordinated HIE infrastructure can support.</td>
<td>EAS delivers real time notifications to a patient’s care team when an admission, or discharge occurs and can provide the attending ED staff with relevant patient information to reduce readmissions and polypharmacy and to enable post discharge follow-up.</td>
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We appreciate your consideration of our comments. Again, these comments are from the lens of the EAS deployment. Please contact Michelle Consolazio at MConsolazio@ainq.com if you have any questions about our comments or if we can provide any additional information that would be helpful.

Thank you,

Michelle Consolazio, MN EAS Project Manager
Date: October 30, 2017

To: Minnesota Department of Health
mn.ehealth.state.mn.us

From: Patti Cullen, CAE
President/CEO
Care Providers of Minnesota

Re: HIE Study Comment

Care Providers of Minnesota is a non-profit membership association with the mission to Empower Members to Performance Excellence. Our 900+ members across Minnesota represent non-profit and for-profit organizations providing services along the full spectrum of post-acute care and long-term services and support. We are the state affiliate for the American Health Care Association/National Center for Assisted Living, and with our national partners we provide solutions for quality care.

Below are Care Providers of Minnesota’s comments on the Minnesota Health Information Exchange (HIE) Legislative Study.

Section A. Request for overall comments:
General Comments:
1. While we are supportive of the proposed “Connected Networks” (Exhibit 5), we do have concerns in general about whether the current approach will lead the state where we want it to go with HIE. Instead of clearly describing the actions needed to implement the “Connected Networks” concept, the study offers options. The study needs to be much clearer about what is needed to make HIE successful in Minnesota.

2. Likewise, for the “Connected Networks” concept to be successful, a formal governance model needs to be included. This includes defining the governance in statute (appointments, representation, authority, rulemaking, etc.). Without a formal governance structure, it is difficult to envision the State, HIos, HDIs, and providers including long-term care and public health, achieving statewide Foundational HIE.

3. We strongly recommend that the study articulate the definitive action steps that are needed.

4. Lastly, we have several editorial/formatting suggestions for the report:
   - We suggest that the study highlights the policies that would best accelerate HIE in Minnesota, and policies that are not optimal would be placed in the appendix.
   - We would begin the report with page 6, And then proceed to the recommended policies (and only those that are recommended).
   - We would also order those policy recommendations requiring legislation first, and then those that do not.
   - We also think a clear statement of the what this is going to accomplish (i.e. goals) is needed for the study’s recommendations to translate into the public and legislative bodies. For example:
     - Foundational HIE save lives!
• Health Information Exchange will save employers, the state’s public programs, and consumers money.
• Consumers will receive improved care and outcomes and when their health information is safely shared with their providers. Improved care and outcomes in turn will save dollars.

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

Question B1: 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?

Comments: While the use of a task force is a good idea, the study needs to move forward with actual and specific solutions (rather than a menu of options). As written, the task force does not appear to be much different than Minnesota Health Information Network (MNHN) as we unable to answer the following key questions:
• How is the entity in the middle of the “Connected Networks” different?
  o Where does it draw authority and/or exist?
• Where do the payors fit in? Payors (and patients) presumably benefit the most from HIE.
• Where’s the leverage to make the HIOs connect with each other and with providers? Payors? Legislators? Governor?
• Who *owns* the middle of the “Connected Networks” model?
• Where do Health Data Intermediaries (HDIs) fit in? What rights to connect with HIOs do HDIs have? How is this enforced?

Question B2: Thinking about your organization (provide specific examples):

Part (a): What gaps does this concept address?
Comment: If successful, it will allow providers to be confident that their choice of vendor will allow them to be connected. Presumably, the concept puts the patient first (though it is not clear).

Part (b): Which coordinated HIE services would be valuable for your organization? Which of these are a higher priority for your organization?
Comment: All of these are valuable. They are basic and foundational:
• 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).

Part (c): What downsides and/or unintended consequences do you see?
Comment: Without statutory authority and a well thought out governance model, the “Connected Networks” concept may not change the current incentives that have restrained Minnesota’s movement toward Foundation HIE for the HIOs, providers, and payors.

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

General Comment: As noted throughout our comments, we think that convening a task force will not be a sufficient tactic toward Foundational HIE unless authority and governance is provided in statute.

An additional concern about the Task Force model is that the lack of formality and authority means that the predictable turnover of key leads/stakeholders is even more problematic.

Question C1: 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?
Comment: This is where a formal governance structure is important, and needed. A model like the Administrative Uniformity Committee (AUC) comes to mind.

We think the following entities should be included:
• DHS (coordinating with Audacious Inquiry)
• MDH
• Payors
• LTC
• Public Health
• Other Providers
• HIOs
• Consumers
These positions would be appointed by the Commissioner of Health.
Question C2: 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.

Comment: Yes, Care Providers of Minnesota would commit member and staff time to develop a plan to implement the recommended “connected networks” model.

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

Question D1: Indicate which, if any, option you and/or your organization would support.

Comment: We support Option #1: Fully align Minnesota law with HIPAA. We also believe the study should formally recommend this approach, and leave the other options in the appendix.

Question D2: 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)

Comment: Option 1 is simpler, and will save the health care system money, allow for more patient care instead of paperwork, and allow for improved care through HIE. We do not see a compelling reason for Minnesota’s policy to conflict with federal law.
From: Children’s Hospitals and Clinics of Minnesota
October 31, 2017

HIE Study Project Team
Minnesota Department of Health
P.O. Box 64882
St. Paul, MN 55164-0882

RE: HIE Study Comments

To the members of the HIE Project Team:

Thank you for the opportunity to provide comments on the draft HIE study findings, proposal, and recommendations.

Children’s Hospitals and Clinics of Minnesota, 2525 Chicago Avenue South Minneapolis, MN 55404 is a Pediatric health care provider.

With respect to health information exchange, we have:
- Established direct point to point connections with other provider organizations.
- Implementing information sharing over a national network.
- Exploring the Encounter Alert Service that is being establish by DHs.
- Implemented EHR specific data management solutions.

We believe that the ability to exchange electronic health information would greatly improve care delivery and reduce costs, and largely agree with the findings offered in the draft report. In particular, we concur that many barriers to fully operational HIE can be associated with the Minnesota’s Health Records Act. In our experience, the MHRA has required Minnesota’s health care community to build an entire infrastructure around a presumption that information should not be shared, even when the opposite opinion is overwhelmingly supported by our patients and their families. This layer of complexity imposes both operational and cultural barriers to a foundational HIE environment. Further, the ability to exchange data in a timely and efficient manner is essential to our ability to perform in a value-based context where we are being paid for patient outcomes instead of patient volume.

As identified by the draft findings, operational challenges include implementing manual work-arounds, purchasing customized technology solutions, and significant resource allocation for training and education to help providers learn how to navigate the MHRA relative to federal laws and regulations. The cultural barriers are equally challenging: some providers will have a negative experience trying to obtain a patient’s records, and as a result, adopt a default practice of ordering new images, labs, or tests instead of attempting to request existing health information. In addition, as noted by the findings, it is extremely difficult to develop industry best practices for health information exchange because the interpretation of how to comply with the MHRA can vary across providers and entities.
We strongly support the recommendation to align the Minnesota Health Records Act to the Health Information Portability and Accountability Act (HIPAA): this statutory change is essential to the success of health information exchange in Minnesota. With respect to Options 1 and 2 as outlined in the draft report, our overwhelming preference is to pursue Option 1: full alignment with federal law. While we appreciate that there may be some value in incremental progress, we would be concerned that any form of partial alignment could create new challenges to our already-complicated environment. Further, if the objective is to achieve foundational HIE in Minnesota, full alignment with HIPAA should be the goal.

Again, on behalf of [organization], we sincerely thank the HIE Project Team, e-Health Advisory Committee, and all of their partners in providing this comprehensive assessment on Health Information Exchange in our state.

Sincerely,

Anna Youngerman
Senior Director, Advocacy and Health Policy
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?
   a. The model is a step in the correct direction.
   b. The model could be strengthened with more integration of the national initiatives, such as Carequality and Commonwell. We should leverage what those initiatives are trying to accomplish rather than start from scratch. Also incorporate the Encounter Alert System as soon as possible to eliminate duplicative efforts.

   Concerns:
   a. What is the financial commitment this model would require? For some of our smaller clinics, the financial costs associated with an HIE are prohibitive.
   b. What data will be available in the proposed network model? For instance without sharing the care plan, our staff finds limited value in the shared data.
   c. What is the compelling use case/reason to utilize the data? Without a use case, more data is results in more data for our clinicians to search through. It will actually make their job more difficult rather than easier.
   d. We use Cerner as our EHR. The model network needs to support non-Epic EHRs and understand the differences between the requirements of the various EHRs.

2. Thinking about your organization (provide specific examples):
   a. What gaps does this concept address?
      • It would reduce our need to provide multiple data exchange processes.
      • It would also address issues we are having with a master patient index.
      • The ability to exchange HIE data with border states.
   b. Which coordinated HIE services would be valuable for your organization? Which of these are a higher priority for your organization?
      • Data exchange
      • Managing patient consent
      • A master patient index
   c. What downsides and/or unintended consequences do you see?
      • Confusion at the provider and patient level in migrating from the current environment to the proposed environment.
      • Additional work effort to rewrite our patient consent agreements.
• Changes in the workflow for providing care. Implementing will require a large amount of effort and salesmanship.

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?
   • DHS and MDH should jointly lead this effort.
   • Primary care representation needs to be increased, both in the number of representatives and in the areas they represent (i.e. specialty care, ambulatory care, out state Minnesota)
   • And while Minnesota has a large Epic EHR installation base, other EHRs are utilized and not interconnected nearly as well as Epic.

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.
   • Children’s Hospital would contribute resources with HIE expertise and knowledge of the HIE landscape in Minnesota to the effort.

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.
   • Option 1 – fully align Minnesota law with HIPAA

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)
   • Ensure the particular needs of a pediatric population are taken into account when modifying the health records act.
CCHF’s response to MDH RFI:
“Minnesota Health Information Exchange Legislative Study Request for Public Comment”
Submitted 10/31/17

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.

CCHF does not support the goal of the Health Information Exchange Working Group and MDH to streamline HIE and create a governing body for HIos participating in HIE. Each of the options presented in the report call for a partial or full repeal of the language in the Minnesota Health Records Act that currently protects individual privacy and consent rights. The cost of this initiative will not only cost millions of dollars in infrastructure expansion, but will also lead to Minnesota patients losing their privacy and consent rights. At least 37 concerned individuals across Minnesota have notified us that they also responded to this request for public comment and expressed their opposition to changing the MHRA. There may be more.

Complete or partial repeal of the MHRA, Minnesota Data Practices Act, and MN’s HIE Oversight law would unravel decades of carefully considered and vetted legislation that protects and establishes data privacy rights for Minnesota patients. Minnesota patients have the right to determine how and with whom their private, personal health information will be exchanged.

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?

The “connected networks” model and efforts to progress through the three stages of Health Information Exchange (HIE) are not in the best interest of maintaining patient control, freedom, and privacy in health care. “Foundational” HIE, or the idea that the information flows with the patient, has a benefit in regards to allowing a patient to choose to transfer information from one physician to another; however, information freely flowing to all health care providers without consent is not in the patient’s best interests. Furthermore, “Foundational” HIE, if used to share patient information outside of the confines of patient-doctor relationships, undermines the privacy and consent rights of patients. If a patient wants a truly unbiased second opinion, he or she should be able to go to a new physician without fearing that the previous diagnosis will be available to the new physician.

Regarding “Robust” and “Optimal” HIE, this free flow of information would be detrimental to patient care, patient privacy, and the patient-doctor relationship. A patient’s information should not be used by a third-party to “manage patient care” nor should it be used to “support community health.” A patient who knows his or her information is shared beyond the walls of the physician’s office may be less inclined to share important information with the physician – especially sensitive health information such as mental health, AIDS/STIs, or other private topics.
A viable alternative to the “connected networks” model is maintaining current privacy and consent provisions of the Minnesota Health Records Act and looking at additional ways to inform the population of health care rights. In addition, maintaining a network capable of HIE, only to be used between physicians only when a patient gives consent and asks for the transfer, allows physicians to care for patients. This HIE should be limited to information needed for physicians to care for the patient, not shared with government and public health agencies. The Minnesota Health Records Act (MHRA), among other things, requires consent for payment, treatment, and health care operations. Often times, a patient is asked to sign one document that includes many different kinds of consent for different purposes. Some ‘consent’ forms specifically state that no changes to the form are allowed. The Minnesota Department of Health should focus on making sure hospitals and physicians are upholding the current consent laws to protect patient rights and confidentiality instead of recommending changes to further reduce patient control, patient privacy, and the patient-doctor relationship.

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

The “connected networks” model for HIE has a primary goal – to access and use private health information, without consent, for managing and tracking public health in the community. Beyond the Constitutional violation of government access, potential consequences include misuse of protected health information (PHI), lack of data integrity, theft of PHI via hacking or theft of network device, fraud and abuse resulting in legal ramifications, increased workload on already over-worked physicians, over-dependence on technology leading to clinical errors, and increased health care costs to develop the IT infrastructure and maintain contracts with HIos. The most significant consequence is the loss of patient control, privacy rights, and consent rights in health care as provided today in the MHRA. Thus, we oppose this plan to limit or repeal the MHRA to enable a statewide connected networks model.

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?

This task force should not be created. The legislature has not given express direction and authority.

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.

Because Citizens’ Council for Health Freedom opposes the “connected networks” model, we would not assist in any process that dismantles the MHRA and Minnesota patients’ privacy and consent rights.

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.

CCHF opposes each of the recommendations because they ALL either repeal the MHRA, or modify portions in a way that is detrimental to patient privacy rights, consent rights, and the patient-doctor relationship.

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)

Citizens' Council for Health Freedom does not agree with the department’s premise that patient care intrinsically benefits from HIE or that the government or a third-party should regulate or influence how a patient is treated based on recommendations to “support community health” or “manage patient care.” Therefore, we OPPOSE each of the recommended options – especially the specific changes listed below:

a. Option #1 (page 19)
   i. Allowing physicians to share information without obtaining patient consent for purposes of payment, treatment, and health care operations.
   ii. Eliminating duration and exceptions for consent requirements
   iii. Eliminating opt-out for record locator service
   iv. Removing privacy protections of MHRA allowing for certain sharing of information to law enforcement and for research
   v. Changing provisions of the Minnesota Data Practices Act

b. Option #1A (page 19)
   i. Fully repealing the MHRA

c. Option #1B (page 20)
   i. Adding a new provision to permit all physicians to no longer follow MHRA privacy requirements regarding disclosure of protected health information (PHI).

d. Option #2 (page 20)
   i. Removing patient consent requirement for treatment, and/or payment, and/or health care operations.
   ii. Removing “certain patient controls for MN patients, especially related to sensitive material”
   iii. Eliminating duration and exceptions for consent requirements
   iv. Changing requirements of opt-out of record locator service
   v. Removing privacy protections of MHRA allowing for certain sharing of information to law enforcement and for research
   vi. Changing provisions of the Minnesota Data Practices Act

Sincerely,

Twila Brase, RN, PHN
President and Co-founder
Citizens' Council for Health Freedom (CCHF)
161 Saint Anthony Ave., Suite 923
Saint Paul, MN 55103
A. Request for overall comments.

The consumer/patient perspective is not represented. The most striking aspect of this report is that the consumer/patient [“patient”] perspective is not addressed. Patients are the most important stakeholders in any discussion about privacy and health data sharing, yet their needs and wants are not discussed in this document.

1. Privacy from a patient perspective. Patients are concerned about what health information is shared and with whom. Today, patients are not even aware of all the information that is in their providers’ EHRs. In other words, what information is shared among provider organizations, payers, government agencies (such as public health organizations, etc.) may or may not include what the patient thinks is included. In addition, patients may not be aware what data has been inadvertently released if a breach of a provider or payer has occurred. This means that patients may not be aware of where and with whom their data has been shared intentionally or inadvertently, and that creates concerns about the safety of sharing data with their providers, depending on their individual preferences and perspectives. Today and in the future, patients are more likely to expect information about when and where their health data has been shared, and payers and providers are starting to meet that expectation with more transparency about where and when patient information is made available to other organizations.

2. Patients’ data sharing needs, Part 1. Patients may find they need healthcare services when they travel, and many older Minnesotans spend extended periods of time in the southern United States or abroad. If they need emergent or ongoing care while out of state, they need a way to share data with a healthcare provider in that geographic location, and they will optimally share that information with their regular physicians when returning to Minnesota. When they have known health problems, seniors’ travel plans can be disrupted because they are afraid that it would be too difficult and even dangerous to be far away from their regular provider organizations.

3. Patients’ data sharing needs, Part 2. Today, for a patient to have one provider share data with another provider, a request needs to be made at one provider to send it to the other, and that could include the ability to receive follow up information as well. For example, a patient could get a referral from a primary care physician to see a specialist with permission from the patient to send health information to that specialist. The specialist can then send information back to the referring physician after the consultation is completed. The patient is not involved in these transactions, so the patient may not be aware of what information is being shared. After the data has been shared, the primary care physician and the specialist may share the data further for their own business
needs and regulatory requirements, and the patient could easily lose track of all the entities and organizations that have some or all of their health information. An issue could arise where the patient discovers an error in the shared data, and figuring out where all the places that data resides would be difficult or impossible.

4. **Health data completeness and accuracy.** When patients go to several providers, they know that their “medical record” is not complete at any one place. Patients with multiple chronic conditions, especially if they have specialists in different provider organizations, have difficulty doing the hard work of keeping all their clinicians informed of their other clinicians’ recommendations, treatment plans, etc. This can be dangerous and/or expensive for patients and 3rd party payers. It is especially true when patients use long term care services, such as home care or nursing home care, as they may not receive accurate or complete data from the patient’s physician or the discharging hospital. Medication lists are especially vulnerable to incomplete and inaccurate data sharing issues, which have been known to result in serious, sometimes life-threatening, complications.¹

**Recommendation: patients should be given the ability to easily aggregate and share their own health information.** ONC has promoted a “consumer mediated” approach for several years, but difficulties sharing data among various vendor products have also limited the ability for patients to choose their own health information repository and tools to support EHR-compatible technologies. A video posted at HealthIT.gov explains what ONC has envisioned. [https://www.healthit.gov/providers-professionals/health-information-exchange/what-hie#consumer-mediated_exchange](https://www.healthit.gov/providers-professionals/health-information-exchange/what-hie#consumer-mediated_exchange). This approach is also promoted in provisions of the [21st Century Cures Act](https://www.healthit.gov/providers-professionals/health-information-exchange/what-hie#consumer-mediated_exchange), which promotes greater access of health information for patients and family caregivers.² Patients could easily be given capabilities similar to provider organizations now that Direct addresses are available for patients.

At a minimum, some effort should be made to solicit patient input for their wants/needs for both privacy protection and data sharing, with some options that inform them of the possibilities. In that way, a plan that is approved will have a good chance of acceptance by legislators, provider organizations and Minnesota citizens now and in the future.

Respectfully submitted,

Sandra Raup, R.D., J.D., M.P.H.
President, Datuit, LLC
sraup@datuit.com
651-894-2814


October 31, 2017

Minnesota Department of Health
625 Robert St N
St Paul, MN 55164

Re: HIE Study Comment

To Minnesota Department of Health:

Epic is an electronic health records developer based in Wisconsin. Many healthcare providers in Minnesota have selected to use Epic as their electronic health record, and we have extensive experience with electronic health records and interoperability in Minnesota and around the world. We appreciate this opportunity to offer comments on Minnesota’s future interoperability direction.

Consent Requirements in MHRA
As you cite in your request for public comment, the growth of interoperability in Minnesota has been impeded by the varied interpretations of the Minnesota Health Records Act (“MHRA”) and the restrictions it imposes. Epic observes fewer electronic exchanges of patient records per visit in Minnesota than in similar states such as Wisconsin, Ohio, or Michigan. Epic users in Minnesota have told us that they attribute this slower adoption to the perceived burden of complying with the state’s consent expectations.

We see significant advantages to both interoperability and the health of Minnesota patients from efforts to align the state’s consent requirements with national policies under HIPAA and to educate providers to ensure clear expectations. Option 1, Alternative A (Strike MHRA for HIPAA Covered Entities and Replace with HIPAA) presents a simple approach to aligning Minnesota with national expectations and we expect that adopting it would significantly accelerate the pace of interoperability in Minnesota. Epic endorses this option.

Connected Networks
In endorsing a “connected networks” model, Minnesota proposes establishing a new entity to develop and manage high value coordinated services to connect all Minnesota HIE networks directly or through an HIO. We are significantly concerned that this approach will have the unintended consequence of actually impeding interoperability in Minnesota rather than promoting it by interfering with national work already happening to connect networks, such as the expansion of Carequality. At best, the state’s work to establish this entity would be wastefully duplicative of efforts already underway nationally, and at worst it could delay Minnesota healthcare providers from being able to adopt interoperability solutions already available. Many of the services proposed by this new entity are already available through other nationwide networks.

Epic discourages the state from creating a new entity in an attempt to connect the networks. Instead, we would encourage Minnesota to endorse existing efforts to further interoperability. In Epic’s view, a better policy would be to reward Minnesota providers who connect to Carequality, which is already established and successful in joining diverse HIE networks across the country.
Certification
Finally, we urge Minnesota to revise its policies to avoid duplicative certification of software already certified under the Office of the National Coordinator’s (ONC) Health Information Technology certification program. The certification program imposed by Minnesota increases expense for Minnesota taxpayers and healthcare providers. Epic users in Minnesota have told us that they have not seen the state’s certification program offer them any benefits commensurate to its additional cost. Epic recommends that the certification program be eliminated for software that has already been certified through the ONC HIT certification program. While registration (recommendation 3) would be preferable to the current process, we do not see even that step as valuable to Minnesota patients when software has already been certified in ONC’s program.

Thank you for your consideration of our feedback.

Sincerely,

Sasha TerMaat
Epic
From: Essentia Health
Date: October 30, 2017
To: MN.eHEalth@state.mn.us
From: Essentia Health
Subject: HIE Study Comment

Minnesota Health Information Exchange Legislative Study Request for Public Comment

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.

Essentia Health, an integrated healthcare system serving patients in rural MN, Wisconsin, North Dakota, and Idaho agrees with the need to further explore and expand HIE options and coordination in MN with a focus on improved accessibility, affordability and adoption. The additional efforts to review MHRA are critical as current state of authorization has seen various interpretations and is often reported as confusing to patients. We appreciate the opportunity for input and consideration.

B. Request for specific comments on the proposed “connected networks” model
1. To what extent do you view the “connected networks” model as heading in the right direction for Minnesota? What suggestions can you offer that would strengthen the concept?
The proposed “connected networks” model is headed in the right direction for the state of MN. Several areas should be addressed in program development to ensure strong support and success. A change to MHRA to streamline and align with HIPAA is necessary, along with education for patients and providers. The concept needs to ensure a coordinated, governed, and standardized effort for managing a master patient index, provider directory, and patient consent preferences. Without oversight and management, the system is prone to inconsistency and inaccuracy; adoption and use will suffer.

An additional consideration for program success is development and support for a long-term funding strategy with specific considerations to encourage small provider participation. HIE technology is a capital investment that must have ongoing financial support so the system and stakeholders remain enrolled. The connected network model should demonstrate a funding strategy beyond current legislature reach to support time to implement, adopt, and optimize system and use to eventually support advancement of overall community health.

2. Thinking about your organization (provide specific examples):
a. What gaps does this concept address?
The connected networks model addresses several HIE gaps specific to the Essentia Health market. Currently some smaller healthcare organizations in our rural market are unable to participate due to cost or technical barriers. Healthcare providers such as dentists, pharmacists and long-term care providers do not participate and create a gap in the comprehensive health record. The model considers MHRA confusion and ensures consent standardization and coordinated governance.

b. Which coordinated HIE services would be valuable for your organization?
Essentia Health is one the many healthcare organizations in MN using the Epic EHR system and our providers and patients benefit from the robust system connectivity between Epic users in MN and beyond. Ensuring HIE accessibility for all healthcare organizations in MN is valuable but also considering impact to the Border States is critical. A patient’s only long-term care option may be across the bridge in Wisconsin. The care coordination should not end at the state line. The opportunity for advancement of record locator service under the coordination of a connected network model is also valuable.
c. What downsides and/or unintended consequences do you see?
A downside to the connected network model is ensuring the states ability to secure and sustain funding. Assuring accessibility and participation are risks to be carefully addressed to ensure options are available. The system is most valuable if there is full participation by all entities. Education and buy-in prior to roll-out are necessary. Authorization and ability to opt-out must be streamlined and clearly defined to ensure success.

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? Consider reviewing programs in North Dakota and Wisconsin to better understand their models. We expect the state to own and govern the program and the task force to include significant healthcare representation across entities and market areas.

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.
Essentia Health will commit resources to implement the recommended connected networks model.

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.
Option 1A: Essentia Health supports modifying the Minnesota Health Records Act to align with HIPAA. We hear frustration and misunderstanding from our patients and alignment will streamline processes and ease care coordination.

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)
Option 1 improves continuity of care in Minnesota and therefore patient satisfaction and safety.
Response to the MN Health Information Exchange legislative study request for public comment.

Meeting Date: October 25th, 2017 revised October 30th, 2017

Fairview and HealthEast Attendees: Dr. Sonja Short, Dr. Bryan Jarabek, Kim Neeser, Lavonne Wieland, Therese McCarthy, Doug Roszell, Don Wagner, Lea McMartin, Ann Warner

Review and feedback on the preliminary recommendations:

- Getting equality for all provides to share patient records is a good thing.
- Opportunities may include the ability to better participate in ACOs and patient care.
- Will current political decisions impact this recommendation?
- Will labs be provided?
- Will images be provided?

Exhibit 3 page 9 - does not show how the patient connects i.e the patient portals to the HIO and HDI

Page 13
1-a – HIO’s should connect to each other to address the ability for all state entities to share information to address the opioid epidemic. This will require organizations to provide development from our Epic teams and the HIOs. Even large organizations are impacted by priorities, costs and resources so funding will become more practical. Ongoing maintenance will continue to require resources and funding.
1-c – The Opioid working team has discussed pain contracts sharing. This could work if all HIO connected. At this time the PMP may be used for the pain contract. One common data type (flag) for a pain contract can be established and mapped into the CCD.
1-d. We need more information on the types of alerting events to respond.

Appendix C page 17
Questions:
What are the financial commitments expected of the Health System?
What are the labor costs and commitments of the Health System?
How does this compete or compliment the current Health System EMR?
How will the end users know that the data is accurate or accessible?
Those with the most data in the state have Epic so what is the incentive?

The opioid business case is using PMP, CVS is on Epic, Surescripts pulls in pharma fills. The state solution will have the most benefit for the specialty groups or smaller provider.
2 Modify MN Health Records Act to align to HIPAA

Appendix D page 18

Questions and Comments:
- We support alignment with HIPAA we selected Option 2 Alt C.
  - The treatment data should flow. The delay in data delay patient care. ROI delays are common with specialty provider treatment.
  - Payment can flow if balance and financial history is not included and will ease system by not having to request the insurance information.

3 – Update MN HIE exchange oversight law to support the coordinated networks model
- Support the adoption of a simplified registration process for marketing HIE technology capabilities in MN to align with Certified EHR technologies established by CMS and ONC
- Support the simplification of health data intermediary registration process for a vendor disclosure of services and ensuring understanding of MN laws. HIO certification will be required. Will this certification be the same process for EHRs?
- Can EHRs function in the same way as an HIO?
- What will this mean for Health Systems? Expand HIO certification to include another level of requirements for systems choosing to connect to the network directly to coordinate services rather than connecting via an HIO
- Enable a mechanism for stakeholders to report misconduct – will this be part of the governance program and agreement?

4. Appropriate funding to leverage matching federal / other opportunities to support the infrastructure development of coordinated services. All systems will view this as an added cost, tax or imposition until it can prove value for the system or patients demand it. Current Epic users already see passed on costs from Epic for the licensure required for the HDI standing. Epic users do not see value in an additional system (HIO). Non Epic users can now connect at the Federal level with Sequoia and Carequality or Epic CareEverywhere.

Page 15

A. Request for overall comments – see above
B-1. The connected networks model is heading in the right direction for MN if it continues to simplify and align with HIPAA. There needs to be some consideration for the amount of Epic users and how that information will be shared or interoperable with the HIOs. Physicians do not want another system to search for records. Either the records are provided by administrative support or somehow linked or alerted via the Epic system. Overall electronic sharing is the right direction and reducing paper even with Epic partners is necessary.
B-2-A. The connected networks may or may not close the gap on sharing patient records.
B-2-B. Our organizations will benefit from the patient identity, provider index and consent management services in that order.
B-2-C The down sides include the potential for two non-integrated systems Epic and an HIO and there will be ongoing work to validate the data between systems. What will be the liability for the provider if they have access to an HIO and do not look at it. Fully integrated systems are necessary.
C-1 The task force to create the connected networks should be made up of the stakeholders impacted by the use of the connected networks similar to the eHealth Advisory group. The Sequoia model should be investigated and possibly leveraged.
C-2 Our organization will continue to participate in the eHealth activities providing part time resources, leadership, logistical support, expertise as needed. We cannot however commit budget or capital investment without the proper approval processes.

D-1 As mentioned above we support alignment with HIPAA Option 2, Alt C with the caveat that we do not understand the impacts of unintended consequences.

D - 2 Benefits included improved communications and alignment with HIPAA. We may not know what the unintended consequences are.
October 31, 2017

Ed Ehlinger, MD
Attn: HIE Study Project Team
Minnesota Department of Health
P.O. Box 64882
St. Paul, MN 55164-0882

Submitted electronically to MN.eHealth@state.mn.us

RE: HIE Study Comments

To the members of the HIE Project Team:

Thank you for the opportunity to provide comments on the draft HIE study findings, proposal, and recommendations.

Gillette Children’s Specialty Healthcare was established in 1897 as the first hospital in the United States dedicated to treating children who have disabilities. While the patients we serve, the conditions we treat, and many other factors have changed over that time, our mission has remained focused on this vulnerable population of children. Our experience has taught us that children who have complex, often multiple, medical conditions require a more advanced, specialized level of medical care than the average pediatric patient.

Gillette’s focus has led us to develop a care model designed to coordinate care and focus on achieving optimal treatment outcomes as defined individually by each patient and family. We have organized our care model around our patients’ most common conditions that primarily affect the musculoskeletal and/or the neurological systems. Our experts work in cross-disciplinary teams to provide care and facilitate coordination by working in conjunction with primary care (community) providers in our patients’ home community. Through this approach, primary care providers remain informed and involved, and patients receive the specialized care they need to thrive. This necessitates a robust sharing of information back and forth between primary care providers and Gillette providers.

It is important that our providers have a complete picture of a patient’s health status and previous medical care. The separate consent requirement for release of health records under the Minnesota Health Records Act (MHRA) makes it more challenging for Gillette providers to obtain needed medical records on a timely basis and negatively impacts effective care coordination as collecting written permission adds significant time and burden when trying to proactively coordinate a patient’s care. Access to external medical records may aid our providers in a timely diagnosis, and may eliminate the need of ordering repeat labs and images. Not having to repeat X-rays reduces the patient’s exposure to radiation. Not having to repeat tests or images reduces costs to families and insurance companies, and even more importantly, reduces the patient’s anxiety level and discomfort.
We believe that the ability to exchange electronic health information would greatly improve care delivery and reduce costs, and largely agree with the findings offered in the draft report. In particular, we concur that many barriers to fully operational HIE can be associated with the MHRA. In our experience, the MHRA has required Minnesota’s health care community to build an entire infrastructure around a presumption that information should not be shared, even when the opposite opinion is overwhelmingly supported by patients and their families. This layer of complexity imposes both operational and cultural barriers to a foundational HIE environment. Further, the ability to exchange data in a timely and efficient manner is essential to our ability to perform in a value-based context where we are being paid for patient outcomes instead of patient volume.

As identified by the draft findings, operational challenges include implementing manual work-arounds, purchasing customized technology solutions, and significant resource allocation for training and education to help providers learn how to navigate the MHRA relative to federal laws and regulations. The cultural barriers are equally challenging: some providers will have a negative experience trying to obtain a patient’s records, and as a result, adopt a default practice of ordering new images, labs, or tests instead of attempting to request existing health information. In addition, as noted by the findings, it is extremely difficult to develop industry best practices for health information exchange because the interpretation of how to comply with the MHRA can vary across providers and entities.

We strongly support the recommendation to align the Minnesota Health Records Act to the Health Information Portability and Accountability Act (HIPAA); this statutory change is essential to the success of health information exchange in Minnesota. With respect to Options 1 and 2 as outlined in the draft report, our overwhelming preference is to pursue Option 1: full alignment with federal law. While we appreciate that there may be some value in incremental progress, we would be concerned that any form of partial alignment could create new challenges to our already-complicated environment. Further, if the objective is to achieve foundational HIE in Minnesota, full alignment with HIPAA should be the goal.

Again, on behalf of Gillette Children’s Specialty Healthcare we sincerely thank the HIE Project Team, e-Health Advisory Committee, and all of their partners in providing this comprehensive assessment on Health Information Exchange in our state.

Sincerely,

Tim Getsay
Vice President, Performance and Information Management
We strongly support MDH’s goal of easing barriers to HIE. Specifically, moving to a HIPAA framework would make sharing patient data for purposes of population health and care coordination easier and more streamlined.

Here are specific responses to Appendix A:

A. Request for overall comments

Agree with the findings and recommendations. Triple aim goals hinge, in part, on a more streamlined, efficient, and inclusive infrastructure for HIE.

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? Strongly agree that the centralized services model is more sustainable than current state.

2. Thinking about your organization (provide specific examples):
   a. What gaps does this concept address? Current state of event alerting is incomplete and error-prone. Provider/patient relationship directory would make alerting systems more useful.
   b. Which coordinated HIE services would be valuable 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? Research examples of the most successful HIEs in other states and learn from their approach.

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)

If we understand Option 1a correctly, it would essential remove the more-restrictive nature of state PHI disclosure laws and essentially adopt HIPAA as the framework. This would maximize the reach of HIE capabilities, reduce the layers of interpretation/complexity/inconsistency, and it would remove barriers to using proven solutions that have already been vetted and refined in other states.

Nancy Garrett, Ph.D.
Chief Analytics Officer and Senior Vice President for Information Technology
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Confidentiality Notice:

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October 31, 2017

Minnesota Department of Health
85 7th Place East, Suite 500
Saint Paul, MN 55101-2198

Submitted via email to mn.ehealth.state.mn.us

Subject: Minnesota Health Information Exchange Legislative Study Request for Public Comment

Dear Mr. LaVenture,

Thank you for the opportunity to submit comments in response to the Minnesota Department of Health’s Request for Comment on the MN Health Information Exchange study. HealthPartners is the largest consumer-governed, nonprofit health care organization in the nation, providing care, coverage, research and education to improve the health of members, patients and the community. Through more than 50 medical clinics, 22 dental clinics and 7 hospitals in Minnesota and Western Wisconsin, we provide care for more than one million patients. This highly integrated and patient focused structure informs our responses to this proposal.

Our overarching goal for HIE in Minnesota is informed by our mission – to improve health and well-being in partnership with our members, patients and community – and our focus on the Triple Aim (improving outcomes, patient experience and affordability). We share with the state the goal that HIE work should be both achievable in a reasonable timeframe with available resources and should support the Triple Aim. Health care is information-driven, and if the information is not available to providers and payers in a timely manner, patients may face unnecessary delays in care and increased cost.

**Overall Comments - Health Information Exchange (HIE)**

The Request for Comments solicits input on the study findings, proposal and recommendations. We believe that the focus of HIE needs to be on interoperability solutions that are both scalable and transferable. There is a significant need to address the “incomplete connections” in the current system. That, however, does not necessarily point to a need for the “Connected Networks” vision, which is large, resource intensive, and potentially isolating. Clinical exchange of information is not limited to care within our state borders. We exchange clinical record data across state lines and with providers in other countries. We need a simple, achievable, flexible, and scalable approach to interoperability that addresses key issues faced by smaller providers,
rural providers and non-Epic providers. It also needs to interact with currently available exchanges such as Carequality. This is important for best care practices and to address emergent issues such as the opioid crisis.

**We believe that solving for more complete connectivity across providers is important – not just providers in Minnesota but wherever our patients receive care.** This should include increased use of electronic medical records, electronic prescribing and e-Prior Authorization, and perhaps even improved provider connectivity to the prescription monitoring program data through electronic medical record systems.

If a Task Force is created, we recommend that the business plan be flexible as to allow a mix of public and private participation, and to ensure the outcome reflects expertise from all sectors. Information technology is fast-changing and there needs to be flexibility to ensure the business plan reflects the ongoing evolution in this field.

**Minnesota Health Records Act**

As an integrated organization, we understand the many challenges presented by the Minnesota Health Records Act (MHRA). Specifically, the MHRA’s requirement that the patient provide written consent for disclosures for virtually any purpose, has a negative impact on the timeliness, quality and coordination of care, and creates administrative burden and patient dissatisfaction. The MHRA disclosure rules do not take into account the types of interactions and information flow necessary for high-quality care, and for transitions between care-delivery settings. It is out of step with the current state of and technological advances in health care.

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) has created a comprehensive framework which also has protection of information as its primary focus, but with carefully considered guardrails that allow for efficient communication among providers, the patient’s health plan, and support system (family, friends, caregivers and others).

Consider, for example, an elderly patient with complex health conditions, who needs assistance, is accompanied to a doctor visit by a family member. HIPAA would allow the provider to have a discussion with the patient about his or her conditions and care needs with the family member in the room, as long as the patient is given the opportunity to object, which can be done verbally. By contrast, the MHRA would require that the patient sign a written consent form. HIPAA recognizes that, even for those disclosures that do not require written authorization, there still must be limits and guardrails in place. Similarly, HIPAA permits certain disclosures for public health and law enforcement purposes, and although patient consent may not be required, there are specific limits on the manner and content of such disclosures to appropriately balance the need for patient privacy.

Given the nuanced framework and protections under HIPAA, and based on our experience in other states, **we support aligning the MHRA release of health records provisions with the HIPAA disclosure rules.** Our experience with HIPAA alignment in Wisconsin has demonstrated
that patient privacy can be well protected while care connections can be made appropriately. We recommend complete alignment of Minnesota law with all of the HIPAA disclosures rules, as picking and choosing among them creates greater risk of unintended consequences. We further recommend that this alignment apply uniformly to all providers, even those who are not considered covered entities under HIPAA, as well as to all other HIPAA covered entities. Failure to include all providers will create an inconsistent patient experience and unnecessary confusion.

Our recommendations focus on the MHRA. However, we strongly endorse the three proposed changes to MN Statutes 72A and the changes to Chapter 13, which are necessary to create a consistent framework around protection of health information.

Having reviewed the detailed options provided by MDH in Appendix D, with specific statutory language, we believe that Option 1B in Appendix D most closely matches the principles we have discussed (with the focus on HIPAA alignment for all disclosures, for all providers and covered entities). We recognize, however, that small changes to proposed language can make for significant changes in effect. Careful attention to definitions, phrasing and cross-references are always needed, but are interdependent and cannot always be determined until the final stages of drafting. Therefore, we have not provided detailed comments about the language in Appendix D at this time, but we look forward to future opportunities to contribute to the discussion.

Our recommendations, which include the following, enable a framework that is designed to protect patient privacy while making it possible to communicate effectively between providers, caregivers and family members.

- aligning the MHRA release of health records provisions with the HIPAA disclosure rules
- this alignment apply uniformly to all providers, even those who are not considered covered entities under HIPAA, as well as to all other HIPAA covered entities
- corresponding changes to MN Statutes 72A and the changes to Chapter 13

They support best patient care, consistent patient experience, and improving affordability— the Triple Aim.

**Summary**

Minnesota needs to focus on moving quickly and effectively to increase the percentage of Minnesota hospitals and clinics that routinely have necessary information available electronically, without creating a major new HIE infrastructure. We also need to focus on removing statutory restrictions that interfere with the ability of health care providers and HIPAA covered entities to coordinate a patient’s care, and that interfere with necessary sharing of information in support of the Triple Aim and other public health purposes.
Thank you for your work on the study document and your research on the impact of the MHRA and its impact on Minnesota. We appreciate the opportunity to provide comments on the draft recommendations for the legislative study on health information exchange in MN. Please let us know if you have any further questions on this matter.

Sincerely,

Donna Zimmerman
Senior Vice President, Government and Community Relations
HealthPartners
October 31, 2017

Marty LaVenture, Director
Jennifer Fritz, Deputy Director
Office of Health Information Technology
MDH, Golden Rule Building
St. Paul, MN 55464

Dear Marty and Jennifer,

Please see below IDEPC’s comments to the HIE Study.

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

We feel the connected networks model is heading in the right direction, although we do have many questions:

- How does this model differ from the failed MN-HIE project?
- How will this be funded? Specifically, is the intent that the Coordinated HIE Services level be publicly funded?
- Will there be a cost to providers or HIOs to use the Coordinated HIE Services?
- Will there be costs to MDH programs to use these services?
- How will MDH trouble-shoot issues in the connected networks model?
- Who is ultimately responsible for ensuring proper data reporting?

Here are comments on the types of services offered by the connected networks model:

- Streamlined reporting: This is the highest priority, to establish protocols, standards and processes for providers or organizations who need to submit public health data to MDH.
- A master person index could be helpful but failed efforts in the past do not bode well for the success of an MPI that MDH could use. In addition, the law that MDH cannot submit data to an MPI would be a barrier to full use of an MPI.
- Provider directory: Medium priority.
- Medication history: Low priority.
- We do not feel it is role of MDH to manage patient consent.
- Where does the responsibility for ensuring data quality/appropriate content of the incoming data lie? At what level, HIO or Coordinated HIE Services or both or other?
Request for specific comments on Recommendation 1: Convene a task force to develop a detailed plan to implement the “connected networks” model:

What organizations should be involved?
- MDH should clearly be at the table, with program representatives as well as management.
- Someone from the Epic Users’ Group.
- An entity with successful Meaningful Use exchange with MDH.
- An entity struggling to submit Meaningful Use data to MDH.
- At the appropriate time, MNIT staff and other technical staff from stakeholders to discuss transport options and security.

What could we commit?

IDEPC would be willing to commit any of the resources listed (resources, expertise, leadership, logistic support, staffing), to assist with the task force.

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

IDEPC supports both options, as it doesn’t look like aligning our Minnesota Medical Records Act with HIPAA should be a problem because HIPAA is actually broader than our law. However, we would like assurances that Minn. Stat. 144.3351, which allows us to collect and share immunization data without patient consent, and 13.3805, subd. 1(b), are not superseded by these changes.

Sincerely,

Emily Emerson, Assistant Division Director
Margo Roddy, VPD Section Manager
Miriam Muscoplat, MIIC Manager
Sarah Solarz, MEDSS Manager
Aaron Bieringer, MIIC Interoperability Coordinator
Patti Segal-Freeman, IDEPC Legal Analyst

CC:
Kristen Ehresmann, IDEPC Division Director
Diane Rydrych, Health Policy Division Director
Karen Welle, Health Policy Assistant Division Director
Dear HIE Study Comment Review Team:

Thank you for the opportunity to provide public comment on theMinnesota Health Information Exchange Legislative Study Request for Public Comment. Please accept my comments below on behalf of Jennen Law Firm. I have over twenty years’ experience advising government and private sector clients on data privacy, security, health care information, and government records and systems.

I am submitting extensive comments on details of the proposed legislative options because I am interested in seeing an appropriate set of legislative changes made to implement your concept(s). HIPAA is a complex law and so is Minnesota MHRA along with the related provisions identified. Thus, any attempt to harmonize parts of these laws carries great risk of misalignment of terms and requirements, which would have the adverse effect of misinterpretation and misapplication of final legal requirements coupled with unnecessary costs, including legal costs for affected entities. My comments are intended to help you spot problematic issues in advance, to help avoid adverse effects.

My comments incorporate the following terms to reference MDH’s published materials.

“Main Document” means the document titled Minnesota Health Information Exchange Legislative Study Request for Public Comment, released by the Minnesota Department of Health, dated 10/2/2017, including its Appendices A-D.

“Option 1 Supplement” means the document titled Minnesota HIE Study MHRA Modifications: Option #1 (“full alignment”), dated 10-02-2017.

RESPONSE to Appendix A, Subsection 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 from?

All stakeholders should be involved in leading this effort, including representatives of individuals and private entities licensed by the state as well as non-licensed entities that may be affected; and representatives from several state executive branch agencies, the state judicial branch, counties, and cities who create/receive/store health information.

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?

My organization would commit expertise and leadership toward drafting policies, procedures, laws, model agreements, and other governance documents to implement concepts and models.

RESPONSE to Appendix A, Subsection 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.

My organization supports the general concepts proposed by Option 1-A and 1-B, but not Option 2. However, we are unable to support the expression and proposed implementation of either Option 1-A or 1-B as presented in the published materials. Unlike the clear, well-written, understandable presentation in the Main Document from pages 1-17, the presentation of legislative options beginning at the bottom of page 18 and continuing through the Option 1 Supplement and Option 2 Supplement was poorly written and very difficult to comprehend. Therefore, our comments focus on various problems in the expression and proposed implementation of Option 1-A and 1-B in hopes that these can be significantly improved before any final report or recommendation is made.

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).

My organization sees benefits and unintended consequences for all the options presented, as explained below under the subheading for each option.

Regarding scope, I think it is important to identify up-front that these proposals as written appear to affect many different entities with different statuses, including private sector health care providers and health plans that are subject to HIPAA; private sector health care providers that are not subject to HIPAA; and state and local government functions that create/receive/store health information that are both subject to HIPAA and not subject to HIPAA. Have the effects of these proposal on these different groups been carefully analyzed and explained? Should government functions be addressed separately?
Option 1, Alternative A

It is not easy to provide comment on Option 1-A because the introductory information conflicts with the actual proposal presented. For example, on page 19 of the Main Document, the subheading says: “Strike MHRA for HIPAA covered entities and replace with HIPAA.” The next sentence says “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.” In contrast to these headings, the proposal at the top of page 1 of Option 1 Supplement proposes merely to add a new section in Minn. Stat. Ch. 144, without identifying where. Consequently, a reader begins with one understanding of the proposal and finishes with another.

Despite conflicting and confusing language, I offer comments on Option 1-A based on the assumption that MDH’s intent is to 1) leave existing MHRA provisions fully intact with no modifications; and 2) add a new Section 144.xxx to define privacy requirements for certain HIPAA covered entities and business associates, presumably to be inserted before or after MHRA (i.e., outside the range of 144.291 to 144.298).

Placement of Proposed Section 144.xxx. The relative placement of Section 144.xxx in Chapter 144 is important and should have been specified. If it is added within the range of MHRA provisions, it will itself be inapplicable to “a provider that is a HIPAA covered entity or for its business associate” because the end of Subd. 2 states that MHRA does not apply to such providers. On the other hand, if it is added outside the range of MHRA provisions, it likely will accomplish its objectives with some minor changes to terminology, as discussed below.

Use of Terms in Section 144.xxx, Subd. 2. Assuming the intent of Option 1-A is to place the proposed new Section 144.xxx outside the numbering range of MHRA, Option 1-A does not clarify how the terms “provider,” “patient,” and “patient information” get their meaning; because if Section 144.xxx, Subd. 2 makes MHRA inapplicable; then so are MHRA provisions defining these terms. However, this dilemma may be easily resolved by a minor revision to terms used in Subd. 2, as follows:

Subd. 2. Privacy. Notwithstanding any law to the contrary, for a provider as defined under MHRA that is a HIPAA covered entity or for its business associate, the privacy of patient information protected health information shall be governed by the HIPAA Privacy Regulations in Code of Federal Regulations title 45, chapter A, subchapter C, part 164, subpart E, sections 164.500 to 164.534, and the Minnesota Health Records Act does not apply.

Notes:

1. The modification above removes state law terms and substitutes HIPAA terms. It accomplishes two things. It fixes the issue of undefined terms (provider, patient, and patient information). It also eliminates the risk that “patient information” may be defined differently than “HIPAA protected health information,” thereby eliminating the risk of state law requiring the application of HIPAA privacy regulations to a set of “patient information” that may be different than the scope of protected health information under HIPAA and that may affect the scope of providers to which this provision applies.
2. The HIPAA term “protected health information” is the appropriate term to use to define the scope of Subd. 2 (rather than the HIPAA term “individually identifiable health information”) because the Privacy Rule applies to “protected health information.” See Exhibit A as a helpful reference to understand the scope of these two related HIPAA terms.

**Scope of Subd. 2.** As drafted, the scope of this proposal to align state law with HIPAA via Subd. 2 is limited to the subset of “providers” under MHRA that also are HIPAA covered entities or their respective business associates (shown as the intersecting area, below, labeled “Targeted providers”). To cover all HIPAA covered health care providers, the scope of Subd. 2 perhaps should not be limited by the definition of provider in MHRA.

[Diagram showing “Providers” under MHRA, Subd. 2 Targeted providers, HIPAA covered HCP & their respective BAs]

**Making MHRA Inapplicable.** Regardless of whether Subd. 2 is modified as described above in our comments, Subd. 2 appears to make each and every part of MHRA inapplicable to the providers targeted by Subd. 2. This result is questionable when there are many parts of MHRA that may be worthwhile to keep, such as many of those in Option 1-B that are preserved (i.e., not modified in Option 1-B by new HIPAA references). If rationale exists to retain so many existing MHRA provisions under Option 1-B, why doesn’t that rationale also apply here under Option 1-A? It could be easily accomplished by adding a simple list of provisions in Subd. 2 that continue to apply to HIPAA covered health care providers. Examples include certain Patient Rights under 144.292, restrictions on the release of videotapes under 144.296, and penalties under 144.298. See Option 1-B for the full list of MHRA provisions that are unaffected by HIPAA-related modifications in that option.

**Modification to Section 72A.501, Subd. 4.** The proposed modification to this provision on page 1 has an obvious grammatical problem that needs correction. The word “and” appears to be needed before “signed by the person.”

**Private classification for all health records held by government entities.** Please provide rationale for this provision, including the intended effect.
Option 1, Alternative B

It is difficult to provide public comment on Option 1-B for several reasons. First, the summary information presented in the Main Document at the top of page 20 doesn’t align with proposed language in Option 1 Supplement (pages 5-17). At the top of page 20, subheading B is worded differently than the corresponding Alternative B heading in Option 1 Supplement (one says “Revise MHRA” and one says “Repeal . . . and replace.” At the top of page 20 the summary says: “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.” In contrast the first revision to MHRA (in 144.291, Subd. 1) strikes out the range of provisions that comprise the Minnesota Health Records Act along with the name “Minnesota Health Records Act.” This first revision also includes a new sentence that states the MHRA does not apply to the disclosure of health records by a provider if that provider is in compliance with HIPAA Privacy Rule provisions, only to be followed by many modified MHRA provisions that would seem to apply to all providers. Finally, at the top of page 5 of the Main Document, the summary includes a list of four bullets, the second of which says: “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.” Reading only the summary, this statement suggests that Option 1-B contains new security and breach provisions, but it actually does not! It would have been significantly more helpful if the published summary included a statement explaining that Option 1-B does not align MHRA with HIPAA security or breach notification rules because such an approach would be too burdensome for non-covered entities. Despite these and other conflicts in the text, I provide comments below based on the assumption that the summary at the top of page 20 of the Main Document is reliable.

Section 144.291, Subd. 1. At the top of page 5 of Option 1 Supplement, I don’t see the point in striking the definitional range of provisions that comprise the MHRA. I think it would be more helpful to leave in place the range of provisions defining the MHRA. In my comments below I will continue to use MHRA as the name for this set of provisions. Keeping the definitional range of provisions in place should not impede your ability to make the other intended changes. Further, the new sentence that begins, “The Minnesota Health Records Act does not apply to the disclosure of health records . . . “ appears incorrect and should be removed in its entirety, leaving Section 144.293 of MHRA to address “Release or Disclosure of Health Records.” On the other hand, it would make sense to take a slightly different approach and turn this sentence into an exemption of specifically named MHRA provisions for HIPAA covered health care providers, to simplify the rest of the HIPAA alignment provisions in MHRA so they could be drafted more cleanly to apply to non-HIPAA providers. However, since this is not the approach described in the summary, my remaining comments do not presume this alternative approach.

Definition of Health Record. In Section 144.291, Subd. 2, I think you should reconsider how you have re-defined the term “Health record” because the HIPAA definition of “protected health information” is much broader than your intended use. The HIPAA definition of protected health information is foundationally based on creation/receipt of individually identifiable health information by entities that meet the HIPAA definitions of health care provider, health plan, and health care clearinghouse. Because this does not appear to align with your intended use in MHRA, I suggest consideration of
another option, as explained below. (As an aid to understand the complexity of the definition of protected health information under HIPAA, see Exhibit A attached to this Letter.

Include the following 3 HIPAA definitions directly in MHRA. Include the entire HIPAA definition for each if that would be more helpful.

“Health information” means health information as defined by HIPAA (45 C.F.R. 160.103).

“Individually identifiable health information” means individually identifiable health information as defined by HIPAA (45 C.F.R. 160.103).

“Protected health information” means protected health information as defined by HIPAA (45 C.F.R. 160.103).

Then define health record in MHRA as follows:

“Health record” means protected health information as defined by HIPAA, except:

in the definition of protected health information, the term “covered entity” is replaced with “Provider” as defined by MHRA; and

in the definition of individually identifiable health information, the phrase “health care provider, health plan, employer, or health care clearinghouse” is replaced with “Provider” as defined by MHRA.

This definition of health record excludes information collected/received by other types of entities and limits it to the individually identifiable health information collected/received by Providers as defined by MHRA.

Although it may be argued that the broader definition as proposed in Option 1 Supplement won’t be harmful when used within MHRA because the definition of provider narrows its actual use, it may be misused in provisions outside of MHRA if such provisions assume the scope of the term is limited to PHI created/received by MHRA providers. An example may already be included at the end of Option 1 Supplement at the bottom of page 17. How does the new Section 13.38 interpret the scope of the term health record? See my comment on that section below for more discussion.

Further, the use of the phrase “patient information that is protected health information” confuses the scope further, such that not all HIPAA health care providers and their PHI as defined by HIPAA are covered by the proposed scheme under Option 1-B.

Whichever direction the definition of health record takes in the final report to the legislature, the rationale for the decision should be included as background information with all these points addressed.

**Notice Requirements.** Near the bottom of page 6, the proposed modification regarding “notice” will have unintended negative consequences if applied to entities who are not HIPAA covered entities. For example, for a non-covered entity to meet the content requirements for HIPAA notice requirements it would have to include a statement that individuals may file complaints with the Secretary of HHS, which should not be applicable to non-covered health care providers. HIPAA notice requirements also make
several references to administrative requirements in 45 C.F.R. § 164.530, which should not be made applicable to non-covered entities as a side effect of a notice requirement.

Instead, consider the following:

For a provider that is a covered entity under HIPAA, the notice requirements of this subdivision are satisfied by that provider’s compliance with all HIPAA Privacy Rule requirements pertaining to Notices of Privacy Practices.

This dichotomy of notice rules for HIPAA covered entities and non-covered entities may be needed to avoid unintended consequences, especially for government entities that fall within the scope of this option that are not HIPAA covered entities. This dichotomy will not negatively impact patients or HIE participation and will allow non-covered government providers to continue to use existing notices practices.

**Release or disclosure of health records.** In Section 144.293, Subd. 2, the proposed language may have unintended negative consequences for entities not subject to HIPAA.

First, the stated range of HIPAA Privacy Rule provisions for disclosures is too broad. It should be limited to 164.500 to 164.528 because Sections 164.530 to 534 do not include any disclosure provisions needed under MHRA. Section 164.530 includes general administrative requirements; Section 164.532 includes transitional provisions pertaining to original HIPAA Privacy Rule implementation dates; and Section 164.534 includes compliance dates for initial implementation of the HIPAA Privacy Rule. Although this Option 1-B may in fact need some transitional provisions pertaining to disclosures similar to some in Section 164.532, they should be drafted separately as part of Option 1-B to address unique transitional issues that may be triggered by Option 1-B. Similarly, although Section 164.530(c) should be included as a requirement for all providers because it is referenced in a key disclosure provision at 164.502(a)(1)(iii), if this Option 1-B requires other administrative requirements similar to those in Section 164.530, they should be specifically identified and drafted separately. If any such new administrative requirements become part of this Option 1-B other than 164.530(c), they should be carefully weighed against the cost of implementation for Minnesota governmental public health, social services, and correctional agencies that may meet the definition of provider under Option 1-B, because these agencies already have administrative protections in place for “private data on individuals” as required by other laws.

Another unintended consequence of Section 144.293, Subd. 2 (as proposed) is that the reference to “disclosures” is too broad. The HIPAA Privacy Rule describes disclosures allowed by all three types of covered entities (health care providers, health plans, and health care clearinghouses). Because MHRA is limited in scope to providers as that term is defined, the allowance of disclosures under HIPAA also should be limited to disclosures authorized or permitted under the Privacy Rule for HIPAA covered entities of the type “health care provider.” To the extent the HIPAA Privacy Rule authorizes or permits a disclosure for health plans or health care clearinghouses but not health care providers, these should not be allowed under MHRA.

Another unintended consequence of Section 144.293, Subd. 2 (as proposed) is that certain disclosures to business associates are permitted under the referenced Privacy Rule provisions, but the term business associates in the Privacy Rule only applies to MHRA providers that are covered entities. Non-
covered MHRA providers do not have business associates. Although the current intention may be to treat vendors of non-HIPAA covered providers similar to business associates of covered health care providers, there is no discussion of this issue in the summary for Option 1-B and there does not appear to be any mechanism/language to implement such.

Finally, proposed Option 1-B does not appear to address provisions of state or federal law, including under HIPAA, that require disclosure. The proposed language only states that providers “may” disclose health records when permitted by HIPAA or other state or federal law.

To resolve the potential negative consequences discussed above, the following language may be considered as a replacement for the proposed Section 144.293, Subd. 2 language:

(1) A provider may disclose health records in the same manner as a HIPAA covered health care provider is permitted to disclose protected health information under HIPAA 45 C.F.R. § 164.500-528. When disclosures are permitted by HIPAA 45 C.F.R. § 164.500-528 to be made to a business associate, a provider that is not a HIPAA covered entity may make such a disclose to a contracted vendor if the contracted vendor has signed an agreement with the provider that is comparable to a business associate agreement between a HIPAA covered health care provider and business associate, as required by HIPAA. A provider that is not a HIPAA covered entity is required to comply with 45 C.F.R. 164.530(c) in the same manner as a HIPAA covered entity, but no other provisions of 45 C.F.R. 164.530.

(2) A provider is required to disclose health records in the same manner as a HIPAA covered health care provider is required to disclose protected health information under HIPAA 45 C.F.R. § 164.500-528. Notwithstanding the foregoing, a provider that is not a HIPAA covered entity is not required to comply with any such disclosure requirements to the Secretary of the U.S. Department of Health and Human Services under HIPAA 45 C.F.R. § 164.500-528.

Note: In the sample text above, I did not include original text allowing providers to disclose health records if “permitted or required by other federal or state law” as included in the proposal because if a disclosure is not permitted under a provision of HIPAA then the release is pre-empted by HIPAA. Of course, 45 C.F.R. § 164.512(a) permits disclosures that are required by state or federal (outside of HIPAA), but this type of disclosure comes with other requirements at 45 C.F.R. § 164.512(a). Other laws that merely authorize a disclosure and do not fit under a HIPAA permitted disclosure are pre-empted by HIPAA.

In addition, more unintended negative consequences (not identified here) may exist when the language of HIPAA 45 C.F.R. § 164.500-528 is applied as proposed in Option 1-B. These may be identified by reading the referenced provisions line-by-line while watching for HIPAA definitions that have not been addressed by MHRA and references to requirements outside the range of the HIPAA provisions cited.

Option 1-B did not provide an explanation as to why “use and disclosure” was not addressed together the way these terms are used together in the HIPAA Privacy Rule. By omitting “use,” some additional unintended negative consequences may arise in the context of disclosures. Regardless of the final direction on this issue, the rationale should be explained.
**Documentation of release.** In Section 144.293, Subd. 9, the proposed language as written may have unintended negative consequences for individuals being served by providers that are not subject to HIPAA due to misalignment of terms. Additional negative consequences likely will result from the lack of a transitional provision for new providers subject to MHRA under the new provider definition that also have not documented disclosures as required by HIPAA or MHRA for the past six years and/or any other time frames that may be referenced.

Subd. 9. Documentation of Release. An individual has the right to receive an accounting from a provider regarding disclosures of health records in accordance with HIPAA 45 C.F.R. 164.528 as such requires a HIPAA covered health care provider to provide an accounting to an individual for disclosures of protected health information.

Additional negative consequences may result from the proposal’s failure to align vendors of providers that are not HIPAA covered entities with business associates.

**Disclosure to law enforcement agency.**

In Section 144.294, Subd. 2, provision (a) appears redundant. It was already covered under Release or disclosure of health records, above.

**Records release for family and caretakers.**

In Section 144.294, Subd. 3, provision (a) appears redundant. It was already covered under Release or disclosure of health records, above.

**Disclosure of Health Records for External Research.**

In Section 144.295, Subd. 1, provision (a) appears redundant. It was already covered under Release or disclosure of health records, above.

**Other Definitions.** HIPAA terms used in the text of MHRA should be added to the Definitions section along with their HIPAA definitions and citations.

**Private classification for all health records held by government entities.** Please provide rationale for intent, word choices, and effect of this provision.

[continue on next page]
Option 2 (All Versions)

All versions of Option 2 are less desirable because they eliminate an extensive set of permitted disclosures under HIPAA at 45 C.F.R. § 164.512 for important government functions.

Many of the comments above for Option 1-B also apply to the manner of drafting under Option 2.

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This concludes my comments on the HIE Study. If you have questions, please contact me.

Thank you.

Best Regards,

Susan Jennen

Attachment

SYJ
Key HIPAA Definitions

◆ **Health Information** means any information, including genetic information, whether oral or recorded in any form or medium, that: (1) Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. 45 CFR 160.103.

◆ **Individually Identifiable Health Information (IIHI)** is information that is a subset of health information, including demographic information collected from an individual, and: (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) That identifies the individual; or (ii) With respect to which there is a reasonable basis to believe the information can be used to identify the individual. 45 CFR 160.103.

◆ **Protected Health Information (PHI)** means individually identifiable health information: (1) Except as provided in paragraph (2) of this definition, that is: (i) Transmitted by electronic media; (ii) Maintained in electronic media; or (iii) Transmitted or maintained in any other form or medium. (2) Protected health information excludes individually identifiable health information: (i) In education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g; (ii) In records described at 20 U.S.C. 1232g(a)(4)(B)(iv); (iii) In employment records held by a covered entity in its role as employer; and (iv) Regarding a person who has been deceased for more than 50 years. 45 CFR 160.103.
From: George Klauser, LSS-Altair Disability led ACO

10/31/17

Public comment from George Klauser, LSS-Altair Disability led ACO that supports 7400 consumers. I have been an advisory member of e-health for in some way over two years.

Response to questions:

A-

Our organization has been the first community led organization in Minnesota to take on the HIE integration, workflow planning and implementation through SIM grants and significant investment from our members in dollars and time.

Candidly after a 3 year investment and commitment to our consumers and members I am quite disappointed in the status of the current HIE situation and have great concerns about the timeliness of an adequate mitigation to the problems stated. The Altair ACO has much at stake with the failed implementation as outlined in your report. We have imbedded HIE use into our workflow and plan to have the first integrated community offered to provide higher quality health outcomes to our consumers/patients offering for people with disabilities.

Based on review of this report and the discussions of the advisory team I do not see a clear path in site in the short term. The is a detailed set of recommendations that present and viable solution, long term but lack specific committed outcomes and milestones to changes that can happen soon to impact those providers that have a significant investment in HIE at present.

While I respect the Governor Dayton’s urgent request to use e-health address the opioid misuse abuse as the priority, I cannot help but feel that the rest of the organizations in the middle of HIE implementation are left waiting without a clear plan of solving the immediate issues that we face as well. I say this as a parent of a son that overdosed on opioid’s in the last year.

My hope is that we find a balanced approach to addressing the opioid misuse abuse while also addressing our immediate problems with HIE implementation. It is simply not right to disregard the time and money already investment by medium size providers such as our organization and others. We too have lives to save!
B-

I get the connected network approach and support it has the long term solution. It does not however provide any short or mid-term solutions that can provide incremental solutions that are desperately needed.

C-

The recommended task for is too government heavy and does not include any representation from the various community organizations that are key stakeholders.

D-

I support the modifications to the Minnesota records act but hear from my Behavioral Health Colleagues there is still much to be resolved. What is the plan?

Submitted:

George J. Klauser

Executive Director, LSS- Altair ACO

E-Health Advisory Member
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?

A: We believe the “connected networks” model would provide a streamlined approach for MN HIE implementation by providing a single, standardized instance for all stakeholder’s ability to share information regardless of sophistication of EHR, use case, or resource allocation. Single “connected networks” model would afford economies of scale in connection costs and resource utilization. In addition, the participation of all MN providers of care available in a single network allows for improved patient care and ability for population health management and ultimately precision medicine.

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.
A: The certified HIO’s have a vested interest in ensuring that health information exchange in MN continues to evolve so should be at the forefront of any of these discussions. Other representation suggestions include: State of MN, Medicaid, other payers, independent providers (hospital, provider clinic), dentist, chiro, optometry, long term care, public health, social services, home care/hospice, pharmacy, and large IDN.

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)

A: We favor option 2.C. as the most easily implemented solution that maintains protection of the patients’ rights regarding their health information. HIPAA alignment is maintained for covered entities. This option also intuitively aligns with current healthcare provider common practice. We would not object to option 2.B. for the same reasons above, and understanding that, in practice, “healthcare operations” is interrupted differently by healthcare providers.
MEDITECH Public Comments

Thank you for allowing MEDITECH to comment on the Minnesota Health Information Exchange Legislative Study.

We are committed to supporting our customer base in achieving the broad goal of health information exchange as it is the foundation to Care Coordination, Value Based Care, Population Health, Accountable Care Organizations, patient safety, decreasing healthcare costs, and patient focused care and engagement. It's one of our pillars and we are committed to continue to bring solutions that allow our customers to readily connect and exchange health information across disparate organizations and vendor without undue burden.

**General Comments**

We are supportive of the efforts in Minnesota to continue to advance the use of Electronic Health Record (EHR) technology and to use those systems to their highest potential for better health information exchange. Technical standards, policies and best practices around use of and adherence to technical standards are essential to a successful health information exchange. We agree that no one single vendor will meet the varied needs of providers across the care continuum and that a true interoperable system means that information must be able to be viewed, accessed and receive health information from other vendor systems.

We encourage to recognize and support the important work and successful exchanges that have already occurred within the healthcare industry and we feel that we need to continue to build on this framework and to not disrupt ongoing efforts that are working. There have been some advances and have overcome barriers with the advent of the EHR Incentive Program and the adoption of standards as promoted by ONC and the Standards and Advisory committee.

We support the advancement of standards and those that are widely accepted (such as HL7 FHIR) so that both patients/consumers and providers can access information safely, effectively without special effort.

**Stakeholder-identified HIE issues and gaps**

We are supportive of the need to establish “foundational” HIE across all providers. A consideration would be to focus on a minimum, common, basic HIE services that can provide the highest value for providers so that they can increase the quality of care for their patients by having information accessible where and when they need it. The use of these common
standards could be implemented in short period of time. In other words, initial focus should be on Foundational and Robust HIE and then Optimal will come later.

Those organizations with a stage 2 or stage 3 certified solution already have the inherent ability to do both foundational and robust HIE but the focus should now be on the use of these solutions. There are too many variances in interoperability solutions and some of these are not geared toward workflow. An HIE should be able to offer services that most health systems already own such as Direct messaging and the Query and Retrieve model. There is also technology utilizing web services in which single sign on and contextual launches can be implemented for a quick win implementation and quick access to health information in other vendor systems for the provider when needed. These already adopted standards should not be discounted when coming up with a common framework for health information exchange.

Alignment with other HIE networks, that are live and sharing information today, should be encouraged as this will bridge the gap even further for those not participating in an HIE or HIO as well as help with the national exchange to help with the treatment of transient patients. These two networks in particular are actively exchanging records today and may adhere to the common framework that the 21st Century Cures Act will try to identify.

Direct messaging could be utilized more as it is payload agnostic and could reach further to those organizations (e.g., long-term and post-acute care, local public health, behavioral health, dentists, pharmacists, social services) that may not have access to fully certified EHR system.

Education is also needed so that both providers and consumers understand the value of health information exchange and how their outcomes can benefit.

**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?**

We are supportive of the proposed solution to reduce fragmented care and potential harm to patients by offering a core set of coordinated services that support foundational HIE. As stated above, start with a minimum of common technologies and optimize those solutions so that users are moving from just having capabilities to the use of health information exchange.

We recognize that there is need for a common framework to common provider directory, a master patient index, and a system for managing patient consent preferences. This will remove three of the most common barriers to interoperability.
We are supportive of the “connected networks” model as the right approach. We are also supportive of building on the successes of current HIE activities and networks. Furthermore, alignment with the ONC priorities and provisions within the 21st Century Cures Act need to be established. Within the year, a list of those health information exchange networks that follow the common framework and agreement will be published. These considerations shall take into account existing trusted exchange frameworks and agreements used by health information networks to avoid the disruption of existing exchanges between participants of health information networks.

We would suggest to consider the implementation with services and mature standards already adopted today such as ADT alerts, Direct messaging, Provider Directories, CCD query and retrieve model.

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?

All stakeholders of interoperability need to be involved in leading this effort. No single organization will solve the issue of interoperability. As an industry, we need to recognize existing frameworks and engage those organizations in order to come up with a standard model for Privacy & Security and patient consent.

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.

We remain committed to the alignment of the national agenda and has agreed to advance nationally accepted standards as well as support efforts to not participate in information blocking.

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.

We are supportive of recommendations that do not require legislative action. We recommend not to disrupt any exchanges that may be working today. We also recommend to keep an eye on 21st Century Cures Act for Common Trust agreement.

We are supportive of patient consent alignment and the modification of 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.

We are supportive of the simplifying Health Data Intermediary (HDI) registration and process for vendor disclosure of services and ensuring understanding of Minnesota laws. We suggest that this process of registration and certification requirements do not go beyond the 2015 certified edition. Additional certification beyond what is required for the EHR incentive programs would be duplicative.
In 2007 the State of Minnesota passed the Health Records Act. This law, most notably, requires health care providers to seek informed consent from their patients when disclosing personal health information. The law also includes important mental health provisions that offers persons living with mental illness specific protections when mental health care information is to be released to family and caregivers.

There are two legislative proposals currently receiving attention that seek to change the MN Health Records Act (MHRA). One proposal completely eliminates the entire statute and the other partially eliminates MHRA. What both proposals seek to do is to substitute existing minnesota law that offers greater privacy protections with a new law that aligns itself with the federal HIPPA law--a law that serves to provide a minimum level of privacy protection. In so doing important privacy protections especially for persons living with mental illness are eliminated.

In both proposals the very important written informed consent requirement is eliminated and replaced with a weaker right to object to disclosure. The objection does not need to be in writing. The provider can “infer from the circumstances” that the patient would object. This broad discretion offered providers will significantly limit important privacy protections originally put into place to protect the disclosure of sensitive information especially mental health care information.

Most concerning, is that the HIPAA proposals eliminate an important mental health care right otherwise found in MN law. If a family member wants to receive mental health care information they must request this in writing, identify the reason why and specify what information they want to receive. Once this has occurred then and only then does the family member living with mental illness make a decision whether they will authorize a release of their very personal, private and sensitive mental health care information. Under the two HIPPA proposals a provider will only be prevented from disclosing mental health care information if there is an objection. Of course this assumes that the person living with mental illness must know they have a right to object and have the wherewithal to assert themselves. It is more just and reasonable to ask if someone wants to release information than to passively wait for them to assert an objection or to simply assume they would object.

It is for these reasons that we caution lawmakers to consider the impact on patients rights if the MHRA is repealed in full or partially. Aligning our law with HIPPA requirements will ease the flow of information but it does so at the expense of adequately protecting patients, especially mental health care patients. Let’s retain the added protections already found in MN law by not changing MHRA.
From: Minnesota Hospital Association

On behalf of the Minnesota Hospital Association (MHA) and our members, which include the 142 hospitals and health systems serving patients and communities throughout the state, we are grateful for the opportunity to provide the following comments on the preliminary recommendations of the Minnesota Health Information Exchange (HIE) Legislative Study.

MHA has been involved with this study from its inception, having participated on the steering committee and in discussions at the e-health advisory group. Overall, we are generally supportive.

General Comments:

MHA has long championed the Triple Aim’s goals of reducing per capita cost of care, improving the health of the population, and improving the care that patients receive. None of this can be achieved without good, robust and actionable HIE. Minnesota has not universally achieved good, robust HIE, which constitutes a significant barrier in our collective ability to advance the Triple Aim.

MHA believes the preliminary recommendations conceptually seek to address the identified barriers in achieving more robust HIE in Minnesota. Furthermore, within some of the options presented in the recommendations, MHA has a strong preference for those that should be presented for legislative action.

Connected network model and convening a task force:

MHA conceptually supports this model as headed in the right direction. As has been the case in the past, participation – both who participates and how actively they participate – in the model and its testing will be a critical factor in its success.

Likewise, the proposed task force will play a key role in enabling the model to succeed. Using the opioid crisis as a real-life use case for a more robust HIE is a pragmatic approach to a proof of concept of the model’s value proposition.

MHA will continue to participate in all HIE activities, including the new task force. Also, we can help identify potential participants and subject matter experts from our membership.

Modifying the Minnesota Health Records Act (MHRA):

MHA strongly supports option #1A. MDH has had several activities over the last few years that all point to the barriers that the misalignment of HIPAA and the MHRA needlessly cause. Full alignment with HIPAA – which itself is a very strong privacy law that has caused a myriad of safeguards to be implemented and has served as the basis for significant enforcement actions and penalties when breached – would remove these barriers and allow for the benefits of robust HIE for all Minnesotans.
While option #1B has some attractiveness in that it puts all entities under the same law, it would be a tremendous burden for entities that are currently not covered under HIPAA. We believe it would be far less disruptive and costly for those entities to continue as they are today. Also, every other state operates in an environment where there are non-covered entities, so Minnesota should be able to do that, too.

MHA understands why the variations under option #2 are offered – it may be more politically palatable under the “it’s better to get half a loaf than nothing at all” perspective. However, none of these alternatives to full alignment with HIPAA will relieve the practical, day-to-day administrative burdens and costs providers incur in having to obtain, record, retain and manage multiple consents from a single patient. For this reason, MHA generally opposes option #2.

However, of the alternatives to full alignment with HIPAA, option #2C is the least objectionable because it covers the three most frequent needs for HIE – treatment, payment, and health care operations. Having to get additional consents for other situations that are covered under HIPAA, such as certain types of research purposes, would create unnecessary administrative burdens. However, because these situations less frequently occur, #2C would be a significant, albeit incomplete, improvement over the current environment.

Again, MHA appreciates the work and collaborative spirit that went into developing these recommendations. After years of consistent recommendations to align our state medical record privacy laws with HIPAA from a wide assortment of task forces, work groups, public officials and policymakers, and health care stakeholders from across the spectrum of providers, health plans, employers, patient advocacy groups, etc., MHA remains committed to advancing policy changes that will advance robust HIE for the benefit of our patients and communities.

Thank you for the opportunity to provide our comments and input on behalf of our members. If you have any questions or concerns, please feel free to contact me any time.

Sincerely,

Mark Sonneborn
Vice President, Health Information & Analytics
The Minnesota Psychological Association is the largest professional group representing psychologists in Minnesota. It is our mission to serve the science of psychology and its applications throughout Minnesota so the interests of public welfare and psychologists are mutually enhanced.

As health care providers, psychologists recognize the importance of sharing health information between providers to avoid duplications, increase coordination and improve the quality of care, and reduce healthcare costs. An active Health Information Exchange process is key to integrating care in Minnesota. We laud your desires to make this process a reality for Minnesota. As you consider this work, we urge you to consider including the whole continuum of care in your stakeholder meetings. Community providers have much to offer to enrich quality of care.

In terms of your proposals to change consent laws related to the Minnesota Health Records Act, we understand that the current laws create roadblocks to sharing key information. While simply changing Minnesota law to reflect HIPAA would be expedient, it may not contain the nuance to the consent process upon which providers and patients in the mental health community have come to rely.

**We urge you to maintain consent for the release of mental health records.**

It is our understanding that robust electronic systems are able to manage more complex permissions systems such that information can flow while privacy at the individual level can be maintained. We believe it is still crucial to request specific release of mental health records with an expiration of the consent. We also encourage you to preserve language about engagement with families when an individual has a mental illness.

Thank you for your consideration about proposed changes to the Minnesota Health Records Act.

Sincerely,

Steve Girardeau, Psy.D., LP
President, Minnesota Psychological Association
October 31, 2017

Karen Soderberg
Project Lead, MN HIE Study
Minnesota Department of Health

RE: Minnesota Health Information Exchange Study

Dear Ms. Soderberg:

On behalf of the Minnesota Medical Association (MMA), I am pleased to submit the comments below in response to the department’s request for public comments on the draft recommendations associated with the legislative study on health information exchange (HIE) in Minnesota.

Overall, the MMA appreciates the work the department has done to produce a well-informed and thoughtful study. The relative immaturity of Minnesota’s statewide health information exchange capacity is a barrier to the delivery of efficient and effective care. The MMA supports the general direction outlined in the department’s recommendations and supports the move toward a coordinated services model that will work for all physicians and other providers across the state, regardless of their particular electronic health record vendor.

Recommendation #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.

The MMA supports ongoing efforts to further define the numerous details associated with development of a “connected networks” model. In addition to governance, finance, and operations issues, further consideration of technical design and structure are also needed. Although legislative authority is not needed to convene a voluntary task force, the MMA has some concern that without clear legislative expectations and timelines the effort may suffer from a lack of urgency, attention, commitment, and participation.

The HIE services that are offered through the coordinated services model will drive value. The initial services outlined in the report represent a good starting point. We are particularly pleased to see the
inclusion of the prescription monitoring program, the optimal use of which is hampered by its current structure/functions. The MMA urges further input and exploration regarding other services that could be added to support care delivery, such as radiology, pathology, and laboratory results; secure messaging; newborn screening results; immunization registry, etc.

The MMA urges the department to include practicing physicians in the ongoing design of the model to ensure that its functionality reflects the experience and needs of those directly caring for patients.

**Recommendation #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.

The MMA strongly supports proposed changes to the Minnesota Health Records Act (MHRA) that would eliminate barriers to sharing information securely among a patient’s care team for purposes of treatment. Full alignment with federal privacy regulations will ensure that patient information is adequately protected while allowing systems to coordinate care and create much-needed cost savings.

Health privacy protections ensure that patients can be candid with their physician and are vital to fostering effective physician-patient relationships. Although well-intentioned, the MHRA, in practice, has prevented physicians from most effectively providing and coordinating care for their patients. Safe and quality care requires timely and accurate information – removing barriers for patients and providers in the MHRA is a meaningful step towards ensuring that Minnesota physicians are able to provide the type of care that their patients need. Beyond sharing information for treatment purposes, however, meaningful health information exchange, care coordination, and public health goals require data access and analysis that is made burdensome by the existing requirements of the MHRA.

Alternatives that stray further from federal alignment, such as options 1B, 2A, and 2B, pose implementation challenges that are likely to outweigh the potential benefit to patient privacy and the physician-patient relationship. The MMA cautions against segmenting privacy protections based on the intended data utilization (i.e., Options 2A and 2B) as such a system would carry forward the most limiting aspects of the MHRA while adding little in the way of patient protection. Additionally, extending federal HIPAA requirements via state law to non-covered entities would be legally challenging and would burden smaller providers with regulations incongruent with the relative privacy risks faced by patients in those settings. Similarly, the extension of the existing MHRA private right of action to violations of federal regulations raises jurisdiction and enforcement questions that must be resolved so that any subsequent legislation is enforceable and has its intended effect.

Alignment with federal regulations will maintain stringent privacy protections for Minnesotans while paving the way for more effective care coordination and quality improvement. The MMA supports
changes that permit sharing of patient information among providers to ensure that physicians have the most timely and accurate information possible.

**Recommendation #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.*

The MMA supports necessary changes to current law to enable implementation of the connected services model, to align with updated federal standards, and to address gaps currently associated with connections to HIOs.

The MMA looks forward to working with the department and other stakeholders to fully realize the potential of more robust health information exchange capacity in Minnesota.

Please feel to contact me or staff at the MMA with any specific questions or concerns.

Sincerely,

George Schoephoerster, MD
President
To Whom It May Concern,

Minnesota is one of only two states whose existing patient data privacy laws are more narrow than federal law. This presents barriers to delivering coordinated, cost-effective and high quality care. These laws (in particular the Minnesota Health Records Act) must be updated to conform with the federal Health Insurance Portability and Accountability Act (HIPAA), while safeguarding patient privacy, to take full advantage of improved care delivery models.

The rising cost of health care is one of the biggest concerns employers face in running their business. Employers are engaging their employees to make sound economic and responsible choices about their health care. In order to do this, it is important that consumers are able to move through the health care system in an efficient manner that allows providers to better coordinate care, improve outcomes, and reduce health care costs.

There is also tremendous pressure on the health care delivery systems to be as efficient as possible while improving health care quality and lower cost. More and more, information is used to measure performance outcomes of doctors, clinics and hospitals to provide consumers with information about best practices and quality of care.

The Minnesota Health Records Act must be changed to reflect evolving models of care while still safeguarding individual privacy. Until these changes are enacted, the ability to reduce duplication of services, improve care coordination, and mitigate errors will be limited.

Our health care system is at a crossroads. The explosion in knowledge, innovation, and capacity to manage chronic and previously disabling or even fatal medical conditions is remarkable. Yet our health care system still falls short on such fundamentals as quality, outcomes, cost and equity. Consumers want to be able to move through the health care system easily as they strive for quality outcomes and greater cost savings, and they expect their medical records and information to be accessible to their health care providers.

Minnesota’s health care delivery systems are changing to include innovative health care delivery models such as medical homes, accountable care organizations and total cost of care structures. These models show promise for improving health outcomes and affordability. Better coordinated care is more effective care, resulting in lower overall costs for the consumers, employers and the health care system. As providers are expected to become more accountable for the quality and care of their patients, they need the tools to manage this care.

In 1996, Congress enacted the federal Health Insurance Portability and Accountability Act (HIPAA), which established national standards for the protection of certain health information. A major goal of the law is to ensure that individuals’ health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care, improve outcomes, and protect the public’s health and well-being. These requirements strike a balance that permits important uses of information, while protecting the privacy of people who seek care and healing.

Federal law already mandates that all states must follow these uniform standards for protecting patient data privacy. Prior to the enactment of HIPAA, Minnesota had its own patient data privacy laws. Minnesota’s law exceeds the federal standards, and while the additional restrictions provide
some extra protection to certain health information, these state laws have created significant challenges for providers to coordinate patient care. They add administrative complexity and cost to operationalize the processes and procedures required under state law. As a result, Minnesota’s additional data privacy requirements hinder the state’s ability to achieve the “Triple Aim,” a national framework to optimize health system performance on three dimensions:

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health care.

The Minnesota Chamber of Commerce recognizes the need for and supports robust protection of personal health care data. We believe this protection can be maintained while advancing the goals of the Triple Aim through efforts to conform Minnesota law with HIPAA.

Thank you for your consideration of these comments. Please feel free to contact me with any questions you may have.

Sincerely,

BENTLEY GRAVES

Director, Health Care and Transportation Policy

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October 31, 2017

Minnesota Department of Health

RE: Minnesota Health Information Exchange Legislative Study Request for Public Comment

To Whom It May Concern:

Thank you for the opportunity to provide comments in response to the preliminary recommendations addressed in the *Minnesota Health Information Exchange Legislative Study Request for Public Comment (Request for Comment)*. The Minnesota Council of Health Plans (Council) is an association of licensed nonprofit health care organizations providing coverage to more than 4.8 million individuals. Member companies include Blue Cross Blue Shield/Blue Plus of Minnesota, HealthPartners, Medica, Hennepin Health, PreferredOne, Sanford Health Plan, and UCare. The Council’s work focuses on health care access to affordable, high quality health care. An important component of high quality health care is the ability to efficiently share health information in an environment that protects patient privacy.

As it relates to the study, the Council supports solutions that seek improved health outcomes for its members through more effective and efficient means of coordinating care and facilitating health care operations. In general, the Council agrees with prioritizing addressing gaps in health information exchange capabilities. Below are specific responses to the *Request for Comment*.

1. **Task Force**

The Council supports a task force that reports to the MN e-Health Advisory Committee to develop a business plan for and establish the “connected networks” model. The Council recommends a time-limited and focused task force with a firm end date to ensure a timely outcome. The Council also suggests that the task force not develop an overly prescriptive business plan and that the plan allow a mix of public and private participation for an outcome that reflects expertise from all sectors. Information technology is fast-changing and there needs to be flexibility built into the process to ensure a high degree of innovation and responsiveness to the needs of the health care environment.

2. **Minnesota Health Records Act and Other State Privacy Law**

The Council strongly supports the recommendation to update Minnesota health information disclosure law consistent with the disclosure requirements in the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). The changes to Minnesota disclosure law should apply uniformly to all providers and covered entities. The Council agrees that one of the biggest barriers to making our health care system work better for
patients are the restrictions in Minnesota law, and in particular, those imposed in the Minnesota Health Records Act (MHRA) in Minnesota Statutes, Chapter 144 and Minnesota Statutes, Chapter 72A, making it difficult to coordinate care and engage in health care operations to achieve better health outcomes.

Health care is information-driven, and if the information is not available to providers and covered entities in a timely manner, patient care suffers, and health care costs are increased. Therefore, the Council supports replacement of Minnesota disclosure law with HIPAA disclosure requirements to facilitate coordination of care and health care operations.

HIPAA has extensive privacy protections in place which were further strengthened at the federal level in 2009 when the Health Information Technology for Economic and Clinical Health Act (HITECH) was enacted. The protections under HIPAA, as amended by HITECH, strike the correct balance in protecting the privacy and security of patient information while enabling the appropriate sharing of information for the delivery of high quality health care.

The Council supports the new disclosure language in Appendix D, Option #1, of the Request for Comment (full alignment with HIPAA) with the caveat that it pertain to covered entities in addition to providers as set forth below. This is consistent with the disclosure requirements in the current MHRA which applies to providers and to covered entities that receive information from providers. The suggested amendment follows:

Section 144.293, subdivision 2. Disclosure of patient records. A provider or a covered entity that receives health records from a provider may disclose health records, if that disclosure is in compliance with the Code of Federal Regulations title 45, chapter A, subchapter C, part 164, subpart E, sections 164.500 to 164.514, irrespective of whether the provider is a covered entity under HIPAA, or if the disclosure is permitted or required by other federal or state law or regulation.

In addition to and consistent with the above, the Council recommends the following amendment to Minnesota Statutes Chapter 72A, as redlined below:

Section 72A.502, subdivision 6. Personal or privileged information may be disclosed without a written authorization if permitted or required by the Code of Federal Regulations title 45, chapter A, subchapter C, part 164, subpart E, sections 164.500 to 164.514, another state or federal law or regulation or in response to a facially valid administrative or judicial order, including a search warrant or subpoena.

Changes to state privacy law in a manner that pertains to all covered entities and not solely to providers is important to prevent the sharing of information from being foiled due to a break in the authorized process. Providers and other appropriate health care stakeholders need the necessary tools to work together to ensure that total cost of care measures are successful in delivering high quality health care while controlling costs. This can only be accomplished through care coordination and health care operations measures that by necessity require a certain degree of sharing of information while protecting patient privacy, as allowed by HIPAA.

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1The suggested amended language is limited to Sections 164.500 to 164.514 of HIPAA because those sections pertain to the disclosure of protected health information.
3. **Federal Funding**

We agree that the state should explore federal funding opportunities for infrastructure development of coordinated services. It is important to keep in mind, however, that restrictions that are often tied to such funds potentially limit outside-the-box thinking and flexibility needed to provide innovative and effective care.

Thank you for your work regarding a study to assess Minnesota’s framework for health information exchange, including requirements in Minnesota Statutes. The Council appreciates the opportunity to comment and looks forward to the release of the final report in February 2018. We hope that the Dayton Administration will champion the legislative changes to the MHRA and other state privacy laws by including them in the administration’s policy proposals for the 2018 legislative session.

Sincerely,

Jim Schowalter
President
October 31, 2017

Ed Ehlinger, MD
Attn: HIE Study Project Team
Minnesota Department of Health
P.O. Box 64882
St. Paul, MN 55164-0882

Submitted electronically to MN.eHealth@state.mn.us

RE: HIE Study Comments

Thank you for the opportunity to provide comments on the draft HIE study findings, proposal, and recommendations.

North Memorial Health is a health system with 2 hospitals, North Memorial Health Hospital and Maple Grove Hospital, 26 clinics including primary, specialty, and urgent care across the Northwest metro area and some rural locations. North operates an expansive emergency response with 9 helicopters serving 6 air bases and 126 ambulances serving 9 ground regions. North Memorial employs over 5,000 team members, including nearly 500 care providers, serving over 55,000 customers per month. While North strives to customize services for a diverse customer population, a large proportion of our population relies on government sponsored insurance for coverage, 48% of net revenue for the health system comes from government payers.

With respect to health information exchange, we have developed communication infrastructure and processes for data exchange, particularly within our health system and our Integrated Health Partnership (IHP), which includes four independent primary care affiliates. While we are currently communicating with our IHP affiliates, information is still limited, especially for those that are not on the Epic EHR platform. We are excited to participate in the efforts led by the Department of Human Services to share relevant health information for Medical Assistance enrollees attributed to an IHP, and while we are currently sharing some information with other health systems and providers, there are multiple barriers and challenges to having access to the necessary, real-time information needed to treat individuals and avoid duplication of services.

We believe the ability to exchange electronic health information could greatly improve care delivery and reduce costs. We agree with most of the findings offered in the draft report, in particular, that many barriers to fully operational HIE are associated with the unique regulations we have in Minnesota’s Health Records Act (MHRA). In our experience, the MHRA has required Minnesota’s health care community to build an entire infrastructure around a presumption that information should not be
shared. This layer of complexity imposes both operational and cultural barriers to a foundational HIE environment. Further, the ability to exchange data in a timely and efficient manner is essential to our ability to perform and succeed in value-based arrangements where payment is directly tied to patient experience and outcomes rather than the volume of visits.

As identified by the draft findings, operational challenges include implementing manual work-arounds, purchasing customized technology solutions, and significant resource allocation for training and education to help providers learn how to navigate the MHRA relative to federal laws and regulations. Internal cultural barriers are equally challenging: providers may experience significant challenges in obtaining patient records, and as a result, order new images, labs, or tests instead of attempting to request existing health information. In addition, it is extremely difficult to develop industry best practices for health information exchange because the interpretation of how to comply with the MHRA can vary across providers and entities.

We strongly support the recommendation to align the Minnesota Health Records Act to the Health Information Portability and Accountability Act (HIPAA): this statutory change is essential to the success of health information exchange in Minnesota. With respect to Options 1 and 2 as outlined in the draft report, our overwhelming preference is to pursue Option 1: full alignment with federal law. While we appreciate that there may be some value in incremental progress, we would be concerned that any form of partial alignment could create new challenges to our already-complicated environment.

Again, on behalf of North Memorial Health, we sincerely thank the HIE Project Team, e-Health Advisory Committee, and all of their partners in providing this comprehensive assessment on Health Information Exchange in our state.

Sincerely,

Kelsey C. Brodsho, JD, MS, CHC
Chief Compliance Officer
October 31, 2017

Commissioner Edward Ehlinger, MD  
Attn: HIE Study Project Team  
Minnesota Department of Health  
P.O. Box 64882  
St. Paul, MN 55164-0882

RE: HIE Study Comments

Greetings:

Thank you for this opportunity to comment on the draft Health Information Exchange Legislative (HIE) Study.

North Shore Health is comprised of a 16-bed Critical Access Hospital, a 37-bed Skilled Nursing Facility, a Home Health Agency and an Ambulance Service, all located in Grand Marais, MN. The next closest hospital, also a Critical Access Hospital, is over 80 miles away. Together with our health care partner, Sawtooth Mountain Clinic, North Shore Health provides the foundation of medical services for our community citizens and visitors.

The Legislative Study contains descriptions of the existing Health Information Exchange models. Unfortunately North Shore Health is best represented as one of the Hospitals in Exhibit 3 – Minnesota’s Current HIE Model – Inefficient Network Connections. North Shore Health and Sawtooth Mountain Clinic each use different electronic medical records. We have created a variety of interfaces to share information about our joint patients. This is definitely not an efficient, nor at times, an effective process. This describes our relationship with an organization with whom we are physically attached. It becomes even more complicated as we transfer patients to other Minnesota medical providers and facilities. The ability to efficiently exchange electronic health information would significantly improve the delivery and coordination of patient care and reduce costs.

The Legislative Study identifies the Minnesota’s Health Records Act (MHRA) as one of the barriers to a fully operational HIE. The MHRA has the presumption that information should not be shared, even though the vast majority of our patients come to us with the expectation their health care information will be shared appropriately. To provide the best care it is essential we be able to share medical information timely and efficiently. Our patients deserve the best care and the MHRA can be an obstacle. The Minnesota Health Records Act (MHRA) should fully align with the Health Information Portability and Accountability Act (HIPAA). Option 1, full alignment between MHRA and HIPAA, should be the selected option.

Once again, we appreciate the opportunity to comment on the Health Information Legislative Study and thank the HIE Project Team and all involved for their efforts on this project.

Sincerely,

Kimber L. Wraalstad, FACHE  
Chief Executive Officer

Kathy Bernier, CCS  
Director of Revenue Cycle/Health Info  
Privacy Officer
Response to:

Request for Public Comment:
Minnesota Health Information Exchange Legislative Study

Submitted by Minnesota Health Care Safety Net Coalition

The Minnesota Health Care Safety Net Coalition (“the Coalition”) is a nonprofit organization whose mission is to improve the health and health care of low-income, uninsured and disadvantaged Minnesotans by uniting and strengthening the safety net community that serves them. The Coalition brings together all sectors of health care who serve these patients including primary care, mental health, substance abuse, dental, hospital and specialty care.

The Minnesota Health Care Safety Net Coalition is in agreement with the background assessment and recommendations contained in the “Minnesota Health Information Exchange Legislative Study Request for Public Comment.” Minnesota patients, providers, health plans, employers and the State of Minnesota are currently paying a high price because of the absence of a functional way for multiple health care providers who treat the same patients to securely share health information with each other. It has become clear through research and the real-life experiences of patients, health professionals and health care organizations that the current health care system is more expensive and less effective in providing optimal, efficient health care and improving patient’s health because of the current fragmentation and lack of information and coordination that currently exists.

The current cost and negative health impact is especially high because the need for better connectivity and information sharing is most severe for the highest cost patients who have the most complex medical, personal and socio-economic circumstances requiring multiple providers and services. Safety net providers serve a higher proportion of these types of patients and, as a result, they see this painful reality every day. Even though the cost of overcoming the barriers to information sharing may seem high, the investment is only a fraction of the health care savings that will result, even without quantifying the value of improving patients’ health, employability and satisfaction with their health care treatment experience that will also result.
The current opioid addiction crisis is a clear example that is reviewed in the Request for Comment (RFC). The lack of an effective method of information sharing and coordination of care means that people with addictions will have easier access to drugs and the addiction will be less likely to be identified and treated earlier. But this is only one of many examples of how fragmentation and lack of coordination negatively affects patients’ health and treatment and results in higher health care costs.

The Coalition agrees with all of the statements from stakeholders describing the problem and its negative consequences for Minnesotans, so we will not repeat them in this letter. The Coalition also generally agrees with the recommendations in the RFC. In our comments, we will focus on areas where we have additional information or comments to add or have suggestions for other options that could be considered.

A. Request for overall comments: The Coalition agrees with and supports the findings and general proposal and recommendations.

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

1. The Coalition supports the proposed model. We think it is heading in the right direction for Minnesota.

2. Regarding the proposal’s impact on safety net providers in particular:
   a. Gaps: Safety net providers need access to affordable interoperable EHR platforms and HIE systems so that real-time health information can be securely exchanged between providers and organizations who share patients or clients.
   b. HIE services: In addition to those services and functions that are described in the RFC, it will be important to include in the connector the ability of providers to connect to and exchange information with community and governmental agencies who are also providing services to particular patients to address socio-economic risk factors and barriers that affect health and treatment to particular patients such as homelessness, language or cultural barriers, or lack of access to nutritious food.
   c. Concerns:
      i. The Coalition has concerns about the potential costs for safety net organizations to participate and their lack of funding and resources to pay these costs. Current payment and funding models do not adequately cover the additional costs and enabling services that safety net providers need to serve populations with high socio-economic complexity. Additionally, safety net providers have higher uncompensated care losses because they provide free and reduced cost care to low-income uninsured and underinsured patients. We recommend that this potential barrier be addressed by the task force as part of the development of the business plan for implementation. Because an investment in this technology and connector model will have a positive return on
investment by lowering future health care costs for the state, health plans, patients and other stakeholders, the Task Force could implement or recommend payment and funding methods that would provide funding to those organizations who do not have the internal resources to participate, justified by the future savings that will be realized.

ii. A second area of concern is with potential implementation barriers for certain patient populations served by safety net providers. Partnership with safety net providers is vital to ensuring that the system works well for all patients and providers, not just those in the “mainstream.” For example, a master patient index that relies on birthdates may run into issues for with some immigrant populations where many people may have the same or similar names and also do know their actual birthdate so often will use January 1st.

iii. A third area of concern that will need to be addressed is the current marketplace and business environment that fosters a disincentive for some provider organizations to share patient information with other providers outside their organization. Sharing information with other providers may reduce an organization’s ability to attract and retain patients and reduce the amount of revenues received for some services. For example, sharing of patient information between a hospital-based organization and a separate community-based primary care clinic for purposes of better coordination of chronic care may achieve the overall desired outcome of reducing the need for emergency room, inpatient and specialty care in the future, but it will also reduce revenues that would otherwise be received by the hospital-based organization for these services, which affects their financial viability. This barrier to the success of a connected network model will need to be fully acknowledged and discussed so that acceptable means can be developed to balance business and marketplace factors affecting individual organizations with the value and benefit to all Minnesotans of better system-wide connectivity.

C. Request for specific comments on Recommendation 1: Convene a Task Force

1. Task force leadership and process: The leadership, structure and process should be designed to ensure that small, independent, safety net and rural providers have a full opportunity to particulate in planning, decision-making, implementation and oversight of the connector.

2. Safety Net Coalition commitments: The Coalition has limited funding and staff resources to offer but is willing to commit to:
   a. Identifying persons to participate on the task force and its committees and work groups to represent safety net providers.
   b. Providing information, data and input from the safety net provider community to the task force.
c. Reviewing and providing comments on proposals, drafts and documents produced by the task force or submitted to the task force by others.

D. Request for Comments on Recommendations on the MN Health Records Act

1. Options: The Coalition supports Option #1: Fully align Minnesota law with HIPAA.

2. Consequences: Minnesota’s unnecessarily restrictive governmental regulations of provider practices are inconsistent with what most patients need and want from the health care system and are a major barrier to Minnesotans receiving high quality, cost-effective services. Current restrictive policies result in higher health care costs and suboptimal treatment outcomes. They also have a strong chilling effect on innovation and research to develop improved health care services, products, medications and technology. For safety net providers, they hamper the ability to provide holistic, coordinated care to patients with many complex and interrelated medical, behavioral health, social, economic and cultural barriers and risk factors affecting their health and treatment.

Contact Information: Michael Scandrett, Executive Director
612-790-2547
mscandrett@msstrat.com
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.

South Central Human Relations Center agrees that exchange of patient information with ALL of the patient’s providers will lead to improved patient care, at a lower cost, and with less frustration and authorization hassles for the patients. We are disappointed that Minnesota is leaning towards the “connected networks” model instead of one state-wide network that would, in time, connect to a future nationwide network. Being a smaller, nonprofit entity, the integration costs will have a significant impact on our budget, and we have seen the example of our neighbors in Southern Prairie Community Care pay this price once already (each of their different EMR systems connected to one small HIE) to connect to Sandlot, a company that now no longer exists, and they are each having to pay this price to do it over again with another HIE – Relay Health – which again might not last long because it only supports a small percentage of the possible users in the state. Having lots of small providers making this large investment, possibly multiple times, could hurt patient care, as those funds would not be available for other needs and would be an unnecessary burden.

We agree that it appears the Epic users do not yet fully understand the benefits that the care providers outside of their system provide to population health care, patient care, and costs to the entire healthcare system, insurance system, and patients. More education seems warranted regarding this.

State requirement and enforcement of a single system that everyone connects to would seem to be the best way to reach the Triple Aim.

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?
See our answer above. We do not think the “connected networks” model is heading in the right direction for Minnesota. We believe a single network model would be best for everyone.

2. Thinking about your organization (provide specific examples):

a. What gaps does this concept address?

This would give us more rapid access to information we currently do not have when treating clients and would assist with patient safety and result in cost savings by not having to run duplicate tests. Relying on patients to report their diagnoses, past and current medications, side effects, and allergies when they are mentally ill is a challenge, and waiting for information from their primary care doctor, specialists, and hospitals after releases are signed and sent is inefficient.

b. Which coordinated HIE services would be valuable for your organization? Which of these are a higher priority for your organization?

a. Alerts would be #1, though we are in the process of setting up alerts for our local hospital, but being mental health, our patients can end up in hospitals and beds all over this state and the surrounding ones.
b. Medication history/CCD would be #2, including prescription monitoring program information, efficiently integrated into the workflow.
c. Master Patient Index, if it was something like Verato, would be useful to match patients correctly.
d. Consent management, which would be much easier if Minnesota were aligned with HIPAA to save on patient and provider confusion.
e. Provider directory for contact information would be nice, up to date credentialing information is not really necessary for us.
f. Streamlined reporting for state and federal requirements would be nice to have.

c. What downsides and/or unintended consequences do you see?

a. We will have to come up with new workflows and rearrangement of duties, but to have this information, it would be worth it.
b. There might be too much information to sort through to find what you are looking for easily.

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?

A large investment of money into small HIO company A, B, C, or D that may fold, and having to do this multiple times, is not a wise investment, from our point of view. In your example, we see no direct connection option for the small provider to the Coordinated HIE Services. Perhaps one large HIO that all smaller providers connect to would stand a better chance of surviving.

It would also have the potential to save us money. In the above example of Southern Prairie, one of those providers uses the same EHR that we do and is already paying the cost to interface with an HIO – Relay Health; however, our only current option is a different HIO vendor setting up in our area of the state – Medicity - and we cannot take advantage of the interface that is already being paid for by a Southern Prairie provider to have our EHR connect to Relay Health. Relay Health is not setting up in our area with our Allina Hospital, Mayo Health Systems Clinic, and other small providers.

Community Mental Health providers in this state use a few different EHR’s, but how many will have to pay for interfaces to differing HIO’s because that is the only option in their area? How long will those small HIO’s last because there are not enough users to support them in this state?

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.

We would support Option #1, full alignment with HIPAA, as providers and all patients are confused and do not understand that Minnesota even has different privacy laws than HIPAA or what they are or how they work. Only the lawyers are making money on these differences and it is hindering patient care.

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)

We see many great advantages to Option #1, full alignment with HIPAA.
The greatest advantage to full alignment is greater understanding for everyone – patients and providers – on what is or is not allowed to be released or is required to comply legally. Instead of trying to learn and reconcile which law is the one that prevails in every incident, there will only be one law to learn or research or explain. Everyone has heard of HIPAA and can Google it and find what they are looking for, but very few know about Minnesota and its multiple privacy laws and even fewer can hash out which law is the one in effect in every possible situation. Often it takes paying an attorney.

We will save money on training employees and clients on the differences between HIPAA and Minnesota laws, as well as attorney fees to assist us when trying to figure out some of these differences in different situations. Of course, there will be a cost to develop a new Notice of Privacy Practices and re-educate employees and clients regarding the changes, but there will be much less information to train them on in the future.

We question Option #1, 144.293 Release or Disclosure of Health Records, Subd. 3 and how requiring a written request from the patient when releasing records from provider to provider for treatment aligns with HIPAA:


Does a physician need a patient's written authorization to send a copy of the patient's medical record to a specialist or other health care provider who will treat the patient?

Answer:

No. The HIPAA Privacy Rule permits a health care provider to disclose protected health information about an individual, without the individual’s authorization, to another health care provider for that provider’s treatment of the individual. See 45 CFR 164.506 and the definition of “treatment” at 45 CFR 164.501.

The change aligning MN law with HIPAA for insurance consent purposes will also save much frustration, time, and money for providers and patients. Currently, our patients are frustrated when we have to call and ask them to sign a new release so that their records can be sent to their insurance company before their bill will get paid, or when they come in for an appointment and we ask them to sign a new release for their insurance company and they did not bring their insurance card with them.

The benefits to alignment can be seen even with the small change made a few years ago to allow an authorization to be good for longer than a year. It made a huge impact on our organization and our clients. Our case managers
no longer had to have unhappy, mentally ill patients sign multiple releases every year over and over. They could now specify a different period of time the release was in effect, and that time period was now of the patients’ choosing. This actually empowered them and made them feel their point of view was valued – not just “Minnesota says it has to be a year at the most.”

We do not see anything mentioned about Psychotherapy Notes and we hope this full alignment with HIPAA will include these. HIPAA carved out an exception for Psychotherapy Notes that says the client or their representative will never have access to them unless the provider determines this is a good idea, but our providers have been reluctant to use them because Minnesota says the clients and their representatives will have access to them. Our providers would like to document the “he said-she said” of a conversation in a Psychotherapy Note for their own purposes, and one of these is when children are in therapy because of their parents. The therapists want to document what the children are saying, but they want to reassure the children that their parents will not read what they said. Currently, they are unable to do this in Minnesota.

Total alignment with HIPAA would help to move us along the continuum to information moving across the country to wherever patients are – whether they get a concussion from skiing in Colorado, or they are a Minnesota “snowbird” living in a warmer climate for the winter, or they are a traveling business person injured in an accident across the country. We are encouraged that Minnesota is considering these changes in this direction.
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.

Option #2: Alternative C
Amend Minnesota Health Records Act (MHRA) to partially align with HIPAA for treatment, payment, and health care operations purposes.

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)

Option #2: Alternative C
Amend MHRA to partially align with HIPAA for treatment, payment, and health care operations purposes.

Our organization holds privacy in high regard. The privacy and security of the information we maintain for our patients is extremely important. The majority of patients expect us to easily and quickly share their health records with their providers. Federal and state initiatives support using health information exchanges and accountable care organizations to improve the quality of care and reduce the cost; MHRA creates a barrier for providers to be able to deliver coordinated care across the continuum. Allowing the release of health records for treatment, payment, and operations would make it easier for patients to receive coordinated, cost-effective, and efficient care.

The current inconsistency in federal and state law makes it challenging to assist patients in efficient care coordination. Other states, such as Wisconsin, have aligned their state laws regarding release of health records for treatment, payment, and operations with the federal HIPAA regulations. Aligning Minnesota law with surrounding states would reduce the confusion and expense that comes with interpreting and complying with varying privacy laws.

Currently, with some exceptions, consents in Minnesota expire after one year. Aligning consent expiration with HIPAA would reduce paperwork for patients.

Option #1: Alternatives A-B
Fully align Minnesota law with HIPAA

On the contrary, if MN law was to fully align with HIPAA, we realize non-covered entities would either need to comply with MHRA, which leaves inconsistencies, or comply fully with HIPAA, which could be burdensome for their organization.
HIE Study Comments

In reading the proposed plan, I am concerned that the many community providers such as in mental health, social service, and home care will not have a prominent place in the discussion. It is the community provider information that is currently left out of exchanges. For individuals with complex health conditions, community providers offer many crucial services that the big systems of care never hear about or include in the plan of care. This fragments services. The connected network model sounds like one more attempt to get large systems of care to communicate with one another. I am honestly appalled at the hubris of large systems of care, mostly using EPIC, to refuse to invest in their communities so that they can get better, more integrated information that would serve Minnesotans. Is this a plan that will bring in other areas of health care, or once again, leave them to fend for themselves?

I am also concerned about the continuing diminutive role for the Department of Human Services (DHS). Many millions of Minnesotans receive care either directly or funded through DHS and the failure to actively include them in planning is in large measure a cause of the disconnected state of Minnesota. Merely giving glancing mention to the Alerting system, and not using this as a building point is very concerning.

I am concerned about funding yet another task force to come up with recommendations. Perhaps Minnesota needs to just bite the bullet and contract with one organization to deliver real Health Information Exchange across the continuum of care.

In reference to the changes to the Minnesota Health Records Act, I generally support moving to the HIPAA standard. However, I’m not sure why the language related to mental health consent to speak with family/loved ones needs to be removed. I understand that the language in option 2 appears to provide the ability to speak to such individuals. Having consent remain for consultation between loved ones and providers is an important safeguard for individuals with mental illness. The consent requirement opens an opportunity to discuss family engagement. Without consent, providers may be hesitant, based on HIPAA’s vague permissions, to share substantive information with family/loved ones and they may be less likely to engage them as partners in healing. Can this language be preserved?

Should you have questions, feel free to contact me at 952-457-3431 or trishas@trishastarkphdlp.com

Best regards,
Trisha A. Stark, Ph.D., LP, MPA
Stratis Health is pleased to offer our expertise and insight in response to the Minnesota Health Information Exchange Legislative Study Request for Public Comment (issued 10/2/2017). Stratis Health is an independent non-profit quality improvement organization committed to improving health care quality and value through collaboration and innovation. It is our privilege to serve as one of 14 federally-designated Medicare Quality Innovation Network-Quality Improvement Organizations (QIN-QIO) for Minnesota, Michigan, and Wisconsin through which we provide in-depth technical assistance and support to health care organizations to improve the quality of care for seniors. From 2010-2016, we served as one of 62 federally-designated Health Information Technology Regional Extension Centers (HIT REC) for Minnesota and North Dakota, assisting 5,200 primary care providers and over 120 rural hospitals implement and optimize electronic health records and being recognized as one of the top HIT RECs in achieving results. We led and supported many Minnesota SIM (State Innovation Model) projects focused on e-Health, and have been active leaders in the Minnesota e-Health Advisory Committee and its workgroups.

We would like to preface our comments on the greater health information exchange (HIE) topic with regard to both Minnesota and national level concerns and observations. Among these are a few topics that were not addressed in Appendix A (Questions for Public Comment) that we think are important to include. Our perspectives and input is compiled from multiple viewpoints within our organization; and our responses include not only specific recommendations, but also consideration intended to trigger further conversation to garner deeper input and thinking for the HIE task force and HIE advisory committee.

Financial sustainability:
How will the technical HIE model be supported and sustained financially (Appendix C, point 2, items a-c address this topic)? The information that will be exchanged and used through the MN HIE network should be quantified in order to identify the gap between the amount of revenue that can be generated by the types of HIE that the model will support and any public funding available. An approach to this is to consider use cases and the value of information that will be used at the point of care. These use case estimates need to be quantified and multiplied by an estimation of the number of transactions. It is essential to understand whether members of the MN HIE exchange are willing to pay a fee on a transaction basis, a single ‘onboarding’ fee, an annual fee (based on size and ability to pay), or some combination of these and other factors. Also, it is important to consider the value of HIE data that is not used immediately at the point of care, but will support data analytics for Accountable Care Organizations (ACOs) and other Advanced Payment Models (APMs). HIE is a foundational technical component for successful operation of ACOs and APMs, and the savings realized is reliant upon obtaining and exchanging accurate and timely patient data.

A starting point:
Our MN model should undertake exchange of clinical, real time patient data as its highest priority. Any other use is secondary to this until this purpose is met, even as planning for future opportunities.
Breadth and depth of the MN HIE model:
Overall, the MN HIE model that is proposed in this document is very broad in its nature. The ‘conceptualization of HIE’ house diagram on page 4 is detailed in following pages. It would be helpful to create detailed use cases that correspond to the three home level concepts (foundation, structure and roof): foundational, robust, and optimal respectively. Implementation of a proposed solution should follow this three-tiered concept and should further be prioritized based on an agreed intersection between need for information, complexity and timeframe of solution, and financial viability of HIE components individually and as part of the whole.

Use cases:
We are emphasizing the need for the MN model and task force work to center itself around the need to mobilize data that is defined by specific use cases that address our major health care provision issues, such as the opioid crisis. Each use case should enumerate the types of data that will be exchanged, stored, mined, and analyzed, as well as concerns around the retention and use of this data. In Appendix C, point 1, item f, the document refers to “Conduct a data requirements assessment among all stakeholder types as part of short and long-range planning and services development.” Preceding a general ‘data requirements assessment,’ stakeholders should define their prioritized use cases which will incorporate and specify what the specific data needs are.

Special attention to patient consent:
The use cases will define how data will be used and how is should flow through the healthcare system. How then does patient consent apply to all these use cases and what if any concerns exist surrounding the retention and use of this data? Is there any intent to de-identify this data at the ‘optimal’ level to use it for community level health (foundational and robust concepts must be patient specific as they are using the data at this point for patient care).

Time is of the essence:
Minnesota is lagging other states in having a comprehensive state-wide HIE solution, despite multiple well intentioned efforts which have engaged key stakeholders. Today’s HIE environment is largely impacted by the presence of a major EHR vendor that enables a majority of sharing transactions to occur between and among these users. Along with other historical and current considerations, this has left mostly small, rural, underserved and non-Epic organizations to rely on workaround exchange solutions or simply not exchange needed patient data. The task force should establish a project timeline that accelerates HIE adoption across Minnesota and includes the small, rural, independent providers as well as other settings of care.

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

B.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?

Shared services:
The MN model has parallels to the “shared services” model that was to be implemented by CHIC but were never fully deployed across MN. The shared services solution requires full buy-in among participants, and we suggest comparing the cooperative landscape at that time to where we currently find ourselves. Has this improved to the degree it needs to for a successful shared services solution, and if not, what improvements are needed? Shared services needs to be more than a suggestion, it should be mandated as part of the MN HIE model. The shared services function has to truly provide for statewide operational and administrative efficiencies for a master patient index, provider directory, provider credentialing, consent management, current/complete medication history, and state and
federal quality reporting. For organizations to connect to shared services, they must see real value to their organization and overall patient care delivery.

Opioid crisis:
Governor Dayton has specifically asked for HIE to help address the opioid crisis, and the recommendations need to support the opioid crisis as a high priority. HIE recommendations and task force should incorporate and leverage the opioid work already being done in MN. How can the proposed model specifically support solutions to the opioid epidemic within our borders and assist in inter-state, national solutions?

Clarification of ‘connections’ in the HIE model:
We recommend identifying “best practices” models in other states that rely on HIE services. These best practices should be translated into specific use cases that any HIE solutions can be based off of. We suggest focusing on prescription drug monitoring and connection to PMP Interconnect. (Are individual provider organizations already doing this through their EHR? Epic?)

The document often refers to ‘connecting’ to an HIO, HDI or the MN model. Overall, some detail behind ‘connections’ and the technical detail would be helpful in terms of what it truly entails and what effort is needed to establish the connection. The range of possible interpretations include creating a secure pathway via the internet (similar to how we connect to our banking or web commerce sites via an SSL (secure socket layer) connection that shows a padlock next to the URL) to something more sophisticated and permanent between two entities that requires an more sophisticated, time intensive and costly solution. Providing detail to the concept of ‘connections’ will help take that model from the conceptual to the practical level and helps to identify where methods of connecting currently exist or where additional infrastructure is needed. This will help lead to quantifying the costs of assembling a practical model by both public and private participants (DHS, the HIOs and HDIs, healthcare providers, etc.).

What is unique to MN?:
What does the MN Model offer that is unique to our state and not duplicated by connecting and utilizing established, trusted networks such as CommonWell and Carequality? What are we intending to establish and maintain that may be duplicative in nature?

Long term vs. shorter term solutions through the HIE model:
It is important to articulate how the MN Model will help us achieve our longer term goals, especially in terms of establishing the ideal healthcare system and how HIE supports this goal. We can then work our way backward into developing a solution that is incremental over time and helps us achieve these longer term HIE goals. In other words, was the MN Model created to solve our near term goals and may have to be reworked in the longer term? Or is it viewed or considered as a stepping stone to something else longer term?

Learning from the past:
Page 12: “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.” It would be helpful to describe the past efforts, and their successes and their failings, in such a way that we are able to leverage the learnings in designing and implementing the solution for the future.

General comments on the model:
The connected networks model is heading in right direction; a strong, well-run coordinated/shared services organization is the critical glue that pulls it all together. The model gives organizations the
option to connect directly to shared services or through an HIO. There is a strong value proposition why organizations should participate (care coordination, ACOs, patient safety).

Beyond MN borders:
The model should address use cases for intra-state interoperability for the types of exchange that go beyond our MN borders. The model should quantify and address the need for these and reference in more detail how national level exchanges and services such as CommonWell and Carequality will be integrated into the MN solution.

B.2 Thinking about your organization (provide specific examples):

a. What gaps does this concept address?

Prescription drug monitoring is important HIE function to support addressing the opioid crisis. To what extent can SureScripts network help contribute to the solution?

At the core of the MN model, we concur that having a strong, coordinated/shared services organization to tie it all together is imperative. It must provide for accurate/current medication history (or the sharing or sourcing of this information) to support prescription monitoring programs. We further endorse the concept of greatly simplifying connections for all participants – requiring only a single connection to an HIO/shared services rather than having to implement and manage multiple connections. Furthermore, the model needs to integrate and consider solution that will support small, rural, underserved providers to participate with HIE and keep them on par with urban environment HIE capabilities.

b. Which coordinated HIE services would be valuable for your organization? Which of these are a higher priority for your organization?

Prescription drug monitoring for opioids in a current top priority and use cases/solutions should address this within the MN model. High priorities additionally include:

- Care coordination and managing care transitions across care settings
- Connecting the non-Epic small, rural, underserved providers to an HIO/shared services function
- Fully supporting and streamlining state and federal quality reporting measures
- Complete current medication history to address opioids, antibiotic stewardship, and patient safety.

c. What downsides and/or unintended consequences do you see?

The answers to these questions (within this public request for comment document) should each be driven by an organizations’ particular use cases. With regard to unintended consequences, we would see any lack of alignment with national standards and HIPAA requirements as building a unique MN model that does not or cannot interoperate with national exchange standards. To quantify current and future trans-border HIE, we need to determine the number of transactions that happen through referrals and exchange solely within MN and where we then need to participate outside the state. The typical extra-MN exchange occurs on the border regions, and there are other cases of Minnesotans traveling outside of MN or those coming into MN for care (intended or emergent care) that will rely on harmonized national exchange standards and consents.
If the new coordinated/shared services lacks the depth of expertise, operational resources and business capabilities to successfully provide a long list of needed shared services to a wide/diverse audience, this will result in further frustration and dramatically hinder/slow HIE progress across MN. Funding is a critical component that needs to be included support the solution.

Concerned small, rural, underserved provider organizations will be left behind as a lower priority in the scheme of establishing the new shared services; this concern also includes other provider types such as long term care, mental health providers, social services, etc.

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

C.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?

The current MN HIOs need to be fully engaged in the coordinated HIE /shared services planning discussions.

We need technical expertise from the HIOs, HDIs, participating healthcare organizations that will utilize the model, and representatives that can describe and speak to national level standards and including Common Well and Care quality.

We should look outside our borders to states and regions who have successfully implemented same or similar models and retain experts to work alongside our MN task force. HIE best practices should be aggregated and incorporated into our MN solution. We are behind other states and the pioneers in these states have much to contribute to our solution. Unique solutions in the HIE world can restrict interoperability beyond our borders when linking to neighboring or other national HIEs. The task force can help identify what truly is ‘unique’ (or not) about our HIE needs within MN and help insure that we are in alignment with standards and solutions on the national level.

The task force should include good representation from the major MN health systems, state government, health plans, HIE business expertise from outside MN, current HIOs, small/rural providers, long term care, consumers, and professional and trade associations such as MHA and MMA. To help further define the expertise on the task force, we need to define the use cases that clearly articulate the problems we are trying to solve. Defining the scope of our HIE work is critical as we still struggle with the definition of HIE. If the scope of our agreed upon ‘HIE definition’ as defined by the use cases is too broad, the task force can help to prioritize and establish phases for implementation that agree with our MN priorities and ability to fund solutions.

C.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.

Stratis Health is able to contribute significant use case examples and current use case needs based on quality improvement projects that we are engaged in, particularly care coordination projects. We can draw upon our experience as the HIT Regional Extension Center, and from our SIM efforts. We can also represent the full continuum of care, including long-term care and home and community based services.
The task force has critical work to complete; it will take dedicated resources to create the business plan, fully engage all needed stakeholders, and create an operational business plan in a complex/challenging environment.

Overall, there is an immediate need for committed resources and funding dedicated to this project. The task force needs dedicated time and resources working together on a daily, regular basis. This perspective underscores an earlier comment about ‘time being of the essence’ as implementing successful HIE is crucial to MN healthcare goals.

The funding and financial sustainability of this model are unclear, including what sources are available to provide the necessary resources (state and federal funding support, subscription/fees allocated to all participants, or other methods to ensure sustainability). Having adequate funding levels to develop, implement and maintain the long list of shared services required across Minnesota is critical to the long-term success of the recommended HIE model.

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.**

   We support for HIPAA covered entities, the recommendation that MHRA be aligned with HIPAA requirements. For non-HIPAA covered providers, we support the MHRA requiring compliance with HIPAA disclosures of PHI as handled by covered entities.

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)**

   Benefits – by aligning with HIPAA simplifies HIE across MN as well with other border states. Improved coordination of care and management of transitions of care; resulting in improved quality and patient safety.

   Unintended consequences – requires non-HIPAA covered providers to comply with HIPAA disclosures (schools, providers that do not bill, small providers).

Contact:

Jennifer P. Lundblad, PhD, MBA  
President & CEO  
Stratis Health  
952-853-8523, jlundblad@stratishealth.org
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.

In an industry that is increasingly value-based and quality-focused, care providers must have the right patient information in real time to make the best decisions possible. It is critical that patient data is accessible to everyone who is a part of a patient’s care journey and has a say in how care is delivered. Surescripts believes that interoperability does not occur until data moves and it takes significant resources – infrastructure, workflow, trust, governance, etc – to get that data to move.

While Surescripts agrees with and supports the Minnesota Department of Health’s vision of moving to a connected network, Surescripts would strongly encourage consideration of the connectivity that already exists today and more finely tune MN DOH’s vision toward information types that are not as widely exchanged. In other words we should build upon existing successes, not recreate the wheel from scratch.

Specifically, the exchange of medication information within Minnesota happens at scale within existing networks and is directly embedded within nearly all EMR workflows. In 2016 alone, 44M comprehensive patient-specific medication histories were delivered from PBMs/pharmacies to MN providers directly through their EMRs. The information is inclusive of opioids, delivered across care settings (ambulatory, acute, long term/post-acute care), for a multitude of purposes (medication reconciliation, informing an electronic prescription, population health, care management, etc.) and across virtually all EMRs. In addition, there has been significant progress to date integrating state PDMPs into the EMR workflow and will continue to be more progress on that front in the coming months/years.

We have also seen the exponential growth of exchange of clinical summary documents among and between disparate EMR systems with the introduction of national initiatives such as Carequality, eHealthExchange and Direct Trust. In 2016 alone, through the use of Surescripts National Record Locator Service and the Carequality Framework, clinicians from 10 health systems across 7 states were able to discover over 43 historical patient visits, nationwide, and successfully retrieve clinical documents for a subset of those visits most relevant to the care they were providing to the patient. Those numbers are growing dramatically as more and more EHR vendors and healthcare organizations realize their patients do not always seek care locally and understand the value of a national network.

Surescripts recommends targeting initiatives toward information types that are not as widely available today such as information derived from within the hospital setting (ex: in-hospital administered medications, diagnosis codes, allergy information, etc.). Surescripts also recommends looking at these as a national initiative rather than limiting connectivity to the state-wide level.

Surescripts supports the findings and recommendations to modify the Minnesota Health Records Act to align more closely with the HIPAA Privacy Rule. Given Surescripts’ experience at a national level, we do believe that states that have health information exchange regulations that are more closely aligned with the HIPAA privacy act support and allow for more timely secure exchange of patient’s health information at the point of care.
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?

As stated above, Surescripts agrees that the “connected networks” model is the right direction, but should take into account progress that has already been made, focus on information exchange in areas that are not as widely available and focus at a national level rather than a state level.

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?

Surescripts encourages participation from all key stakeholder groups including standards organizations (ex: NCPDP, HL7, etc.), health systems, healthcare providers, technology vendor organizations represented in the state, and other successful network conveners like Sequoia Project/Carequality. Surescripts would recommend consideration of leveraging the successful Carequality Framework already established by the Sequoia Project.

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.

Surescripts would commit a representative to participate on the task force. Surescripts would bring our expertise and experience supporting health information exchange within and among all states across the nation.

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.

Surescripts supports Option #1: Fully align Minnesota law with HIPAA. Option 1 Alternative A is preferred; Option 1 Alternative B is also supported but only if targeted toward the specific information areas that are not as widely available today (in hospital administered meds, allergy information, diagnosis codes, etc.). We believe medication history information to already be widely available and adopted by providers.

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)
Option 1 Alternative A will benefit the secure exchange of critical health information without the added challenges that are brought on by additional consent requirements. HIPAA privacy rules adequately govern the disclosure of PHI between covered entities for treatment, payment and operations. Fully aligning Minnesota law with HIPAA will maintain consistency with the majority of states and allow for easier exchange of information within the state and across state lines. Committing resources toward driving information exchange in areas that already have widely adopted information exchange could result in duplicative costs/infrastructures/workflows which would lead to less efficient and ultimately worse patient care
Individual responses

To whom it may concern,

My privacy and control in health care are very important to me and many others. Unlike the Minnesota Health Records Act (MHRA), HIPAA is a permissive data-sharing law and does not protect my privacy. I fully support the MHRA which is the strongest health care privacy law in the nation. It requires my consent to share my personal information. My privacy rights are incredibly important to the patient-doctor relationship and should not be eliminated just because people who want my data don’t want to ask me for my consent. My medical records and personal information are mine and should remain in my control. I absolutely oppose any changes to, or the repeal of the MHRA.

Sincerely,
Cheryl Allen
Eden Prairie, MN

--

MHRA is the strongest health care law in the nation and requires my consent to share personal information and therefore I Strongly Oppose doing away with the MHRA law!!! Sincerely, Ann Amundson

To whom it may concern.

I wish to go on record as being opposed to any changes in the Mn Health Records Act(MHRA). I want the privacy of my personal health records protected.

Marvel Anderson
Lilydale, MN

--

To Whom it may concern,

As a Minnesota citizen, I value my privacy and my personal control of my health care.

The current MHRA is a very strong protector of my medical data, requiring my consent to share that information.

I vehemently oppose any changes or repeal of the current MHRA.

Sincerely,
Pam Anderson
Center City, MN

--

My privacy my choices in health care mean a lot to me.

Minnesota's Health Records Act is the real deal. HIPAA is a JOKE.

When it comes to Minnesota's Health Records Act I want you to LEAVE IT ALONE!

Any tinkering on your part is a direct assault on my medical privacy.
Don't touch Minnesota's Health Records Act to my request.
Thank you for your attention to my request.
Val Baertlein
--
My privacy and control in health care are very important to me and many others. Unlike the Minnesota Health Records Act (MHRA), HIPAA is a permissive data-sharing law and does not protect my privacy. I fully support the MHRA which is the strongest health care privacy law in the nation. It requires my consent to share my personal information. My privacy rights are incredibly important to the patient-doctor relationship and should not be eliminated just because people who want my data don’t want to ask me for my consent. My medical records and personal information are mine and should remain in my control. I absolutely oppose any changes to, or the repeal of the MHRA.
Sincerely,
R. E. Bauer
--
To whom it may concern,
My privacy and control in health care are very important to me and many others.
We must ensure that the Minnesota Health Records Act (MHRA) continues to be unchanged and remain the strongest health care privacy law in the nation. My consent must be required in sharing my personal information and these privacy rights must remain protected as part of the patient-doctor relationship. My medical records and personal information are mine and should remain in my control.

I absolutely oppose any changes to, or the repeal of the MHRA.

Sincerely,
Kathleen Bedor
Minneapolis, MN
--
Medical privacy is very important. Getting my written consent to share my information should be a requirement. You shouldn’t be expanding who can have access to my information without my consent. HIPAA is a permissive law, allowing broad outsider access without consent (2.2 million entities, plus government agencies) and MN should not conform to it. I oppose getting rid of the protective language in the Minnesota Health Records Act.
Bill Bergen
--
I absolutely oppose any changes to, or the repeal of the MHRA.
Francis M Branch
Garrison, Mn 56450
--
To the Committee:
Privacy in medical care is very important to our citizens. Unlike the MHRA, HIPAA allows data sharing and does not protect privacy. MN needs to retain MHRA as it is a good law for our protection. My medical records and personal information must remain in MY control. I totally oppose any changes to or the repeal of the MHRA.

Thank you,

Sue Campbell
Marcell, MN

To: Minnesota Dept of Health

I value my privacy in and control of my health care. I urge you not to change or repeal the Minnesota Health Records Act (MHRA).

Sincerely,
Roger Carlson
Arden Hills, MN

I am completely opposed to any changes of the MHRA and any privacy laws.

It's outrageous!! You just don't want to be bothered with complying with laws and rules yourself. You should be required to remove all identifying information and only collect the minimal amount of data and you should have to prove to all Minnesota citizens that what you are doing has any value. We don't want you telling our doctors what they have to do and collecting our private information! Its outrageous that you are only soliciting information from organizations and not private citizens. All done in secrecy to strip citizens of their rights.

You are no tin compliance with HIPPA protection of private health information recommendations at all and you should be sanctioned!!

Anonymous

To whom it may concern,

My privacy and control in health care are very important to me and many others. Unlike the Minnesota Health Records Act (MHRA), HIPAA is a permissive data-sharing law and does not protect my privacy. I fully support the MHRA which is the strongest health care privacy law in the nation. It requires my consent to share my personal information. My privacy rights are incredibly important to the patient-doctor relationship and should not be eliminated just because people who want my data don’t want to ask me for my consent. This is totally against my rights. My medical records and personal information are mine and should remain in my control. Please help with this matter. I absolutely oppose any changes to, or the repeal of the MHRA.

Sincerely,
Rose Crawford
Tenaha, Texas

Good afternoon,
Below you will find my answers to the questions in Appendix A. I answer this as an individual and patient, as well as a former transit director working on similar data problems with MnDOT in regards to efficiencies of rider data and reservations.

B.

1. I believe the connected network is a step in the right direction. The main point I see as working to strengthening this would be private data companies like EPIC understanding the needs for open communication between systems. If they can’t play nice in the sand box, it would be like me needing to bring my computer everywhere if I was only able to access my email from one location/computer. The world is moving faster and as a patient we need to know that if we visit another facility/specialist, etc, we know that our records follow us. The concerns I have is the vulnerability of hacking to our data. The alternative is what is being described as a solution where patients can actively have their records available to them to email or download directly to the next provider.

C.

1. I think the main providers of these data sources like EPIC should be at the table. They need to understand the full need to play nice and help us efficiently share the data. Also there should be representation from medical providers on the front lines as they are the ones with daily access. Let them help decide how the task force moves forward and what info is pertinent to move between providers and organizations.

D.

1. personally, I think the alignment with HIPAA in Option one looks the best.

Sincerely,
Ryan Damlo
--

To Whom it May Concern,

My privacy and control in health care are very important to me and many others. Unlike the Minnesota Health Records Act (MHRA), HIPAA is a permissive data-sharing law and does not protect my privacy. I fully support the MHRA which is the strongest health care privacy law in the nation. It requires my consent to share my personal information. My privacy rights are incredibly important to the patient-doctor relationship and should not be eliminated just because people who want my data don’t want to ask me for my consent. My medical records and personal information are mine and should remain in my control. I absolutely oppose any changes to, or the repeal of the MHRA.

Sincerely,
Alan Deutsch
St Paul MN
--

To Whom it May Concern,

Please preserve the Minnesota Health Records Act as it currently is written. It is the strongest health privacy law in the nation of which we should be proud.

MHRA requires patient consent before health records are shared. A patient should have control over who sees his or her records. Children’s records should be protected also.

HIPAA does not protect privacy.
Of all the privacy rights that need to be respected, the right to healthcare privacy should rank very high.

Sincerely,
Judith Enfield
Shoreview, Mn.

To Whom It May Concern:

My privacy and control in health care are very important to me and many others. Unlike the Minnesota Health Records Act (MHRA), HIPAA is a permissive data-sharing law and does not protect my privacy. I fully support the MHRA which is the strongest health care privacy law in the nation. It requires my consent to share my personal information. My privacy rights are incredibly important to the patient-doctor relationship and should not be eliminated just because people who want my data don’t want to ask me for my consent. My medical records and personal information are mine and should remain in my control. I absolutely oppose any changes to, or the repeal of the MHRA.

Thank you very much for your consideration. This is very important to me and many others in Minnesota.

Kathryn Engebrit

To whom it may concern,

I totally oppose any changes to or repeal of the MHRA. My privacy and control in health care are very important to me and many others. Unlike the MHRA, HIPAA is a permissive data-sharing law and does not protect my privacy. I fully support the MHRA which is the strongest health care privacy law in the nation. It requires my consent to share my personal information. My privacy rights are incredibly important to the patient-doctor relationship and should not be eliminated just because people who want my data don’t want to ask me for my consent. My medical records and personal information are mine and should remain in my control. I absolutely oppose any changes to, or the repeal of the MHRA.

Sincerely,
Laura Evenson
Isanti, MN

To whom it may concern,

My privacy and control in health care are very important to me and many others. Unlike the Minnesota Health Records Act (MHRA), HIPAA is a permissive data-sharing law and does not protect my privacy. I fully support the MHRA which is the strongest health care privacy law in the nation. It requires my consent to share my personal information. My privacy rights are incredibly important to the patient-doctor relationship and should not be eliminated just because people who want my data don’t want to ask me for my consent. My medical records and personal information are mine and should remain in my control. I absolutely oppose any changes to, or the repeal of the MHRA.
Sincerely,

Nora Felton

--

To whom it may concern,

My privacy and control in health care are very important to me and many others. Unlike the Minnesota Health Records Act (MHRA), HIPAA is a permissive data-sharing law and does not protect my privacy. I fully support the MHRA which is the strongest health care privacy law in the nation. It requires my consent to share my personal information. My privacy rights are incredibly important to the patient-doctor relationship and should not be eliminated just because people who want my data don’t want to ask me for my consent. My medical records and personal information are mine and should remain in my control. I absolutely oppose any changes to, or the repeal of the MHRA.

Sincerely,

Sandy Floyd
Liberty, In

--

To whom it may concern,

My privacy and control in health care are very important to me.

HIPAA is a permissive data-sharing law and does not protect my privacy. On the other hand, the Minnesota Health Records Act (MHRA) is the strongest health care privacy law in the nation. I fully support the MHRA which is It requires my consent to share my personal information. My medical records and personal information are mine and should remain in my control.

I strongly oppose any changes to, or the repeal of the MHRA.

Sincerely,

LuAnn Fredrickson
Le Center, MN

--

To whom it may concern,

As it stands, the MHRA is the strongest health care privacy law in our country. Any & all sharing of our personal information & medical records will be at our discretion & not at anyone or institutions discretion. We want this law to remain strong & we oppose any changes to it &/or repeal of the MHRA.

Sincerely,

Russel & Kally Fritchman
Maple Grove, MN. 55311

--

To: the MDH
Re: Proposed changes in the Minnesota Health Records Act (MHRA)
Why “fix” something that’s not broken? I oppose the changes being contemplated.

We have serious problems with Big Data now aside from the privacy issue. The changes planned would certainly endanger patient privacy. Big Data itself needs to be revisited.

Thanks,

RWG
Robert W. Geist MD
North Oaks, MN 55127-6310

--

To whom it may concern,

My privacy and control in health care are very important to me and many others. Unlike the Minnesota Health Records Act (MHRA), HIPAA is a permissive data-sharing law and does not protect my privacy. I fully support the MHRA which is the strongest health care privacy law in the nation. It requires my consent to share my personal information. My privacy rights are incredibly important to the patient-doctor relationship and should not be eliminated just because people who want my data don’t want to ask me for my consent. My medical records and personal information are mine and should remain in my control. I absolutely oppose any changes to, or the repeal of the MHRA.

Sincerely,

Steven M. Green
Crystal, MN

--

Current MN privacy and consent requirements must be retained. No Changes should be made to the MN Health Records Act.

Matt Grunewald
St Clair, MN

--

To whom it may concern,

My privacy and control in health care are very important to me and many others. Unlike the Minnesota Health Records Act (MHRA), HIPAA is a permissive data-sharing law and does not protect my privacy. In fact, in 1973, the U.S. Supreme court found that the First, Fourth, Ninth and Fourteenth Amendments of the U.S. Constitution protect an individual's "zone of privacy". It appears you might want to now take this privacy away. I fully support the MHRA which is the strongest health care privacy law in the nation. It requires my consent to share my personal information. My privacy rights are incredibly important to the patient-doctor relationship and should not be eliminated just because people who want my data don’t want to ask me for my consent. My medical records and personal information are mine and should remain in my control. I absolutely oppose any changes to, or the repeal of the MHRA.

Sincerely,

Carol Heitzman
Little Canada, MN
To whom it may concern,

My privacy and control in health care are very important to me and many others. Unlike the Minnesota Health Records Act (MHRA), HIPAA is a permissive data-sharing law and does not protect my privacy. I fully support the MHRA which is the strongest health care privacy law in the nation. It requires my consent to share my personal information. My privacy rights are incredibly important to the patient-doctor relationship and should not be eliminated just because people who want my data don’t want to ask me for my consent. My medical records and personal information are mine and should remain in my control. I absolutely oppose any changes to, or the repeal of the MHRA.

Sincerely,

Gordon & Carolyn Heitzman
White Bear Lake, MN

--

To whom it may concern,

My privacy and control in health care are very important to me and many others. Unlike the Minnesota Health Records Act (MHRA), HIPAA is a permissive data-sharing law and does not protect my privacy. I fully support the MHRA which is the strongest health care privacy law in the nation. It requires my consent to share my personal information. My privacy rights are incredibly important to the patient-doctor relationship and should not be eliminated just because people who want my data don’t want to ask me for my consent. My medical records and personal information are mine and should remain in my control. I unequivocally oppose any changes to, or the repeal of the MHRA.

Sincerely,

Elizabeth Henderson
Bloomington, MN

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To whom it may concern,

My medical privacy is of utmost importance to me. Getting my written consent to share my information, is necessary. I do not want access expanded to my information without my consent. I fully support the MHRA which is the strongest health care privacy law in the nation. My medical records and personal information are mine and should remain in my control. I ABSOLUTELY OPPOSE ANY CHANGES TO, OR THE REPEAL OF THE MHRA.

Sincerely,

Geraldine Howie
Dennison, MN 55018

--

To whom it may concern,

My medical records and personal information are mine and should remain in my control; therefore, I absolutely oppose any changes to or the repeal of the MHRA. I fully support the MHRA which is the
strongest health care privacy law in the nation. It requires my consent to share personal information. My privacy rights are important to the patient-doctor relationship and should not be eliminated just because people who want my data don't want to ask my consent. HIPPA does not protect my privacy. Please respect my request -- I absolutely oppose any changes to or the repeal of the MHRA.

Sincerely,

Nancy Johnson

St. Paul, MN

--

to whom it may concern,

My privacy and control in health care are very important to me and many others. Unlike the Minnesota Health Records Act (MHRA), HIPAA is a permissive data-sharing law and does not protect my privacy. I fully support the MHRA which is the strongest health care privacy law in the nation. It requires my consent to share my personal information. My privacy rights are incredibly important to the patient-doctor relationship and should not be eliminated just because people who want my data don't want to ask me for my consent. My medical records and personal information are mine and should remain in my control. I absolutely oppose any changes to, or the repeal of the MHRA.

Sincerely,

Miriam and Richard Jondahl

Waite Park, Mn 56387

--

To Whom it May Concern:

My privacy and control of my health care are very important to me. Unlike the Minnesota Health Records Act (MHRA), HIPAA is a permissive data-sharing law, and does NOT protect my privacy. I fully support MHRA. It requires my consent to share my personal data.

I ABSOLUTELY OPPOSE any changes to, or repeal of MHRA.

Sincerely,

Llona Jorgenson

Princeton MN 55371

--

MDH,

This is providing comment on your HIE Legislative Study Request.

Each of the options presented in the report call for a partial or full repeal of the language in the MN Health Records Act that protects privacy and consent rights. Repeal (partial or total) would undo decades of carefully considered and vetted legislation that protects and establishes right of MN patients in addition to requirements for providers. MN patients have the right to determine how and with whom their Health information will be exchanged--and that right must be protected and remain solely with the patient.

Wayne Kallestad
Vadnais Heights, MN 55127

To whom it may concern:

I understand that the MN Health Record Act may be changed. My family and I oppose any changes to MHRA! The current MHRA protects our medical privacy, and we’d like to keep it that way. Two of my children have medical issues, and they and I don’t want entities of any sort invading their privacy without their consent. You may think that HIPAA protects their rights to privacy, but it does not. HIPAA is a broad data-sharing law, that allows many entities access to our medical records. So the state of MN needs to maintain its own standards of who has access to our medical records with the MHRA. NO CHANGES SHOULD BE MADE TO MHRA!

Thank you,

Sue Kieffer
Apple Valley, MN

--

To whom it may concern,

My privacy and control in health care are very important to me and many others. Unlike the Minnesota Health Records Act (MHRA), HIPAA is a permissive data-sharing law and does not protect my privacy. I fully support the MHRA which is the strongest health care privacy law in the nation. It requires my consent to share my personal information. My privacy rights are incredibly important to the patient-doctor relationship and should not be eliminated just because people who want my data don’t want to ask me for my consent. My medical records and personal information are mine and should remain in my control. I absolutely oppose any changes to, or the repeal of the MHRA.

Sincerely,
Scott Kimball
Chaska, MN

--

To whom it may concern,

My privacy and control in health care are very important to me and many others. Unlike the Minnesota Health Records Act (MHRA), HIPAA is a permissive data-sharing law and does not protect my privacy. I fully support the MHRA which is the strongest health care privacy law in the nation. It requires my consent to share my personal information. My privacy rights are incredibly important to the patient-doctor relationship and should not be eliminated just because people who want my data don’t want to ask me for my consent. My medical records and personal information are mine and should remain in my control. I absolutely oppose any changes to, or the repeal of the MHRA.

Lee Kurisko MD
Laraine Kurisko PhD
To the Minnesota Department of Health:

Please recommend NO CHANGES to the MN Health Records Act (MHRA). I value my privacy, especially in the doctor/patient relationship. The MHRA protects my privacy. HIPPA gives away my personal records without my permission to a long list of public and private entities whose interest in my data has nothing to do with my medical needs.

I oppose any change to the MHRA. It's doing a great job of protecting us. Please don't leave us Minnesotans at the mercy of HIPPA.

Thanks,
Constance Lee
Eagan, MN

--

Dear MDH,

I understand that there is a move afoot to sacrifice my medical privacy for the dubious benefit of various deep pocketed research and medical industry players.

We have the best privacy laws in the country and I want to keep it that way.

I will be very unhappy if Minnesota makes detrimental changes to the MHRA.

It's bad enough that the state mandates my doctor to waste his time on EHRs and their progeny, regardless of my preferences and his good judgement. It is outrageous to give a third party the right to my medical information without my explicit consent.

No changes to the MHRA.

Thank you,
-dgl-
Donald Lee
Eagan, MN 55121

--

To whom it may concern,

My privacy and control in health care are very important to me and many others. Unlike the Minnesota Health Records Act (MHRA), HIPAA is a permissive data-sharing law and does not protect my privacy. I fully support the MHRA which is the strongest health care privacy law in the nation. It requires my consent to share my personal information. My privacy rights are incredibly important to the patient-doctor relationship and should not be eliminated just because people who want my data don’t want to ask me for my consent. My medical records and personal information are mine and should remain in my control. I absolutely oppose any changes to, or the repeal of the MHRA.

Nancy Lovestrand
Minneapolis, MN
To whom it may concern,

My privacy and control in health care are very important to me and many others. Unlike the Minnesota Health Records Act (MHRA), HIPAA is a permissive data-sharing law and does not protect my privacy. I fully support the MHRA which is the strongest health care privacy law in the nation. It requires my consent to share my personal information. My privacy rights are incredibly important to the patient-doctor relationship and should not be eliminated just because people who want my data don’t want to ask me for my consent. My medical records and personal information are mine and should remain in my control. I absolutely oppose any changes to, or the repeal of the MHRA.

Sincerely,

Judith Lundquist
St. Paul, MN

--

To whom it may concern,

My privacy and control in healthcare is very important to me. HIPAA is a permissive data-sharing law and does NOT protect my privacy!

I support the MHRA, which is the strongest healthcare privacy law in the country! It requires MY consent to share my personal individual information. My privacy rights are very important to the doctor-patient relationship and should NOT be eliminated just because people who want my data don't want to ask me for my consent.

My medical records and personal information are NOT anyone's business other than to whom I give my consent to have it!

I adamantly oppose any changes to, or the repeal of, the MHRA!!!!

Sincerely,

Ann Martinsen
West Saint Paul, MN

--

Do not modify the MN Health Records Act.

There is absolutely no reason for Social Services to have access to my health information. That information belongs to me and no government agency should have access to it without my consent. Furthermore, my health information should not be widely shared, even among health care providers. I own my information and will take responsibility to see that it is shared as I deem necessary.

Paul Mayer
Glencoe, MN

--

To Whom It May Concern,

We strongly oppose any changes to, or the repeal of, the Minnesota Health Records Act (MHRA). We feel very strongly about having our health care information kept private. We are proud to live in
Minnesota where we have the MHRA, which is the strongest health care privacy law in the nation. It requires our consent to share our personal information. Our medical records and personal information are ours and should remain in our control.

Most sincerely,
John and Corinne McKenzie
Braham, MN 55006

--

I wanted my voice to be heard and state that I oppose getting rid of the protective language in the Minnesota Health Records Act. My consent in my personal well fare/health is important, and is valid. This is my personal business and my consent should be required, you shouldn’t be expanding who can have access to my information without my consent.

Thank you,
Lynn McLaughlin

--

My privacy and control in health care are very important to me and many others. Unlike the Minnesota Health Records Act (MHRA), HIPAA is a permissive data-sharing law and does not protect my privacy. I fully support the MHRA which is the strongest health care privacy law in the nation. It requires my consent to share my personal information. My privacy rights are incredibly important to the patient-doctor relationship and should not be eliminated just because people who want my data don’t want to ask me for my consent. My medical records and personal information are mine and should remain in my control. I absolutely oppose any changes to, or the repeal of the MHRA.

Best regards,
Robb Meyers
Maple Grove MN 55311

--

I am a permanent resident of Minnesota, a citizen of the USA, and a voter.

I feel very strongly that current Minnesota privacy and consent requirements must be retained. I fervently support MHRA, and believe that no changes should be made to it.

Minnesota citizens have a right to determine how and with whom their personal health records are shared.

Please convey my thoughts to the appropriate parties.

John Murlowski
St. Paul, MN

--

The State of Minnesota currently has a excellent health care information privacy law in place. I strongly recommend that our state keep this law in place. I am hopeful that this email will raise the concern of any change to this law. Thank you for your time and assistance. Glenn Nelson Pipestone, MN

--
Dear MN Health and Human Services,

I do not want any of my health care information shared with anyone without my explicit permission. I want to retain the privacy protections we have in place.

Please do not compromise my HIPPA information!

Sincerely,

Deborah Nichols

--

To Whom This May Concern,

Please Accept and Consider the Following Comments and Concerns,

My privacy and right to manage my own health care are very important to me and my family. Unbeknown to most people, the HIPAA is a permissive data-sharing law and does not protect my privacy. I therefore fully and vehemently support the Minnesota Health Records Act (MHRA) which is the strongest health care privacy law in the nation. It requires my consent before any sharing of my personal information. Every person’s privacy rights are essential to all patient-doctor relationships and should not be eliminated just because people who want someone’s data don’t want to ask for their consent. Just as it is with every citizen of this great state, my medical records and personal information are mine and should fundamentally remain in my control. I absolutely oppose any changes to, or the repeal of the MHRA.

Sincerely,

Mark

Mark Olson

Big Lake, MN 55309

--

To Whom It May Concern,

I enjoy living in Minnesota, which has the strongest health care privacy law in the nation! I do not want that to change! My privacy rights are very important to me because it affects my relationship with my doctor. I do not want other people to have my private information. That information should always be under my control. It distresses me that other people are trying to obtain my private information and you are considering changing the law so they can do it! I DO NOT want any changes to, or the repeal of the MHRA.

Sincerely,

Susan Pilon

Blaine, MN

--

To whom it may concern,
My medical records and all personal information are mine and should remain in my control. Period. I am in complete opposition to any changes in or the repeal of the MHRA.

Unlike the Minnesota Health Records Act, HIPAA does not protect my privacy and is a permissive data-sharing law which in and of itself is no good. Do not eliminate my privacy rights just because there are people/organizations who want my data without their ‘inconvenience’ of needing to ask me for my consent. My privacy, by law, trumps others inconvenience and need for requesting the information.

Privacy rights are an important part of the patient-doctor relationship and should continue to be covered with the MHRA.

I fully support the MHRA and am proud that MN has the strongest healthcare privacy law in the nation - so don’t screw that up!

I repeat: I am in complete opposition to any changes in or the repeal of the MHRA.

Sincerely,

Jane Pooler
Edina, Minnesota
--

To whom it may concern,

My privacy and control in health care are very important to me and many others. Unlike the Minnesota Health Records Act (MHRA), HIPAA is a permissive data-sharing law and does not protect my privacy. I fully support the MHRA which is the strongest health care privacy law in the nation. It requires my consent to share my personal information. My privacy rights are incredibly important to the patient-doctor relationship and should not be eliminated just because people who want my data don’t want to ask me for my consent. My medical records and personal information are mine and should remain in my control. I absolutely oppose any changes to, or the repeal of the MHRA.

Sincerely,

Rosemary Przybilla
Royalton, MN
--

To whom it may concern,

My privacy and control in health care are very important to me and many others. Unlike the Minnesota Health Records Act (MHRA), HIPAA is a permissive data-sharing law and does not protect my privacy. I fully support the MHRA which is the strongest health care privacy law in the nation. It requires my consent to share my personal information. My privacy rights are incredibly important to the patient-doctor relationship and should not be eliminated just because people who want my data don’t want to ask me for my consent. My medical records and personal information are mine and should remain in my control. I absolutely oppose any changes to, or the repeal of the MHRA.

Sincerely,

Hersh Reddi
Abilene, TX

To whom it may concern,

My privacy and control in health care are very important to me and many others. Unlike the Minnesota Health Records Act (MHRA), HIPAA is a permissive data-sharing law and does not protect my privacy. I fully support the MHRA which is the strongest health care privacy law in the nation. It requires my consent to share my personal information. My privacy rights are incredibly important to the patient-doctor relationship and should not be eliminated just because people who want my data don’t want to ask me for my consent. My medical records and personal information are mine and should remain in my control. I absolutely oppose any changes to, or the repeal of the MHRA.

Sincerely,
Howard Reitz
Roseville, MN

To whom it may concern,

The privacy of my medical records and control in health care are very important to me and many others. HIPAA is a permissive data-sharing law and does not protect my privacy. I fully support the Minnesota Health Records Act (MHRA) which is the strongest health care privacy law in the nation. It requires my consent to share my personal information. My privacy rights are incredibly important to the patient-doctor relationship and should not be eliminated just because people who want my data don’t want to ask me for my consent. My medical records and personal information are mine and should remain in my control. I absolutely oppose any changes to, or the repeal of the MHRA.

Sincerely,
Kristi Rosenquist
Mazeppa, MN 55956

To whom it may concern,

My privacy and control in health care are very important to me and many others. Unlike the Minnesota Health Records Act (MHRA), HIPAA is a permissive data-sharing law and does not protect my privacy. I fully support the MHRA which is the strongest health care privacy law in the nation. It requires my consent to share my personal information. My privacy rights are incredibly important to the patient-doctor relationship and should not be eliminated just because people who want my data don’t want to ask me for my consent. My medical records and personal information are mine and should remain in my control. I absolutely oppose any changes to, or the repeal of the MHRA.

Thank you and have a terrific day.

James M Sarkkinen
To whom it may concern,

My privacy and control in health care are very important to me and many others. Unlike the Minnesota Health Records Act (MHRA), HIPAA is a permissive data-sharing law and does not protect my privacy. I fully support the MHRA which is the strongest health care privacy law in the nation. It requires my consent to share my personal information. My privacy rights are incredibly important to the patient-doctor relationship and should not be eliminated just because people who want my data don’t want to ask me for my consent. My medical records and personal information are mine and should remain in my control. I absolutely oppose any changes to, or the repeal of the MHRA.

Sincerely,

Dr. Greg Sheehan

1. To what extent do you view this “connected networks” model as heading in the right direction for Minnesota?

It’s not the right direction for Minnesota. A person’s health information should be private. The government has no business accessing anyone’s private health information without their express consent, except in the case of serious criminal investigations, in which case, a search warrant should be required. Governments that have access to everyone’s health care records can, and will, identify individuals whose lives are considered to be not worth the cost of their health care. Those individuals, or their legal representatives, will be harassed, pressured, and possibly tricked into signing "advance directives" which are not in the best interest of the patient. This is already happening. Do we really want to make Minnesota more and more like Nazi Germany? Respect life. Keep private information private.

Arlene Sheldon

Please do not take away my medical privacy. My privacy is important, and sharing my data without my written consent should not be allowed.

Please do not change the MHRA.

Jeffrey Simon
Eden Prairie, MN

To whom it does concern:

I say NO to any changes being made to the MN Health Records Act (MHRA)

Candy Sina
Healthcare Compliance Consulting, Inc.
Shoreview, MN 55126
--

NO CHANGES should be made to the MN Health Records Act (MHRA).

REGARDS,
Kim Skaro
--

To whom it may concern,

My privacy and control in health care are very important to me and many others. Unlike the Minnesota Health Records Act (MHRA), HIPAA is a permissive data-sharing law and does not protect my privacy. I fully support the MHRA which is the strongest health care privacy law in the nation. It requires my consent to share my personal information. My privacy rights are incredibly important to the patient-doctor relationship and should not be eliminated just because people who want my data don’t want to ask me for my consent. My medical records and personal information are mine and should remain in my control. I absolutely oppose any changes to, or the repeal of the MHRA.

Sincerely,

Traci L Smith
Rochester, Minnesota
--

This is obviously another attempt to weaken the privacy laws we have in place, and in no way should there be any changes made to the MNRA).

Respectfully, Gary and Judy Swenson, Spicer, MN
--

To whom it may concern,

I want MN to maintain my privacy and control in health care.
The MHRA is the strongest health care privacy law in the nation. It protects the privacy of my relationship between me and my doctor.
I don’t want to give up any of this privacy (HIPAA does not protect my privacy well enough) just to make things more convenient for people who want access to my data.
My medical records are mine and should remain in my control.
People who want access to my records must be required to obtain my consent.
I STRONGLY OPPOSE ANY CHANGES TO, OR THE REPEAL OF THE MHRA!!!!!

Sincerely,

Jill Thompson
To whom it may concern,

My privacy and control in health care are very important to me and many others. Unlike the Minnesota Health Records Act (MHRA), HIPAA is a permissive data-sharing law and does not protect my privacy. I fully support the MHRA which is the strongest health care privacy law in the nation. It requires my consent to share my personal information. My privacy rights are incredibly important to the patient-doctor relationship and should not be eliminated just because people who want my data don’t want to ask me for my consent. My medical records and personal information are mine and should remain in my control. I absolutely oppose any changes to, or the repeal of the MHRA.

Sincerely,

Joel Troumbly
Cohasset, MN 55721

Respectfully i want to tell you that my health is between my doctor and i,and I don't want anybody else in it, my privacy is for me only, Im a free man made to the image of the creator, the god of the universe the holy of holies,where all man and women are created equal with certain unalienable rights, and I have a right to PRIVACY, the same as you and everybody else, so please do not interfere, my health is not up for sale or business, neither my personal information, please do the right thing and leave it alone, thank you. Marcelo Uribe

Minnesota Department of Health

To whom it may concern,

My privacy and control in health care are very important to me and many others. Unlike the Minnesota Health Records Act (MHRA), HIPAA is a permissive data-sharing law and does not protect my privacy. I fully support the MHRA which is the strongest health care privacy law in the nation. It requires my consent to share my personal information. My privacy rights are incredibly important to the patient-doctor relationship and should not be eliminated just because people who want my data don’t want to ask me for my consent. My medical records and personal information are mine and should remain in my control. I absolutely oppose any changes to, or the repeal of the MHRA.

Sincerely,

Andrea Wagner
Farwell, MN 56327

Minnesota Department of Health

To whom it may concern,

My privacy and control in health care are very important to me and many others. Unlike the Minnesota Health Records Act (MHRA), HIPAA is a permissive data-sharing law and does not protect my privacy. I fully support the MHRA which is the strongest health care privacy law in the nation. It requires my consent to share my personal information. My privacy rights are incredibly important to the patient-doctor relationship and should not be eliminated just because people who want my data don’t want to ask me for my consent. My medical records and personal information are mine and should remain in my control. I absolutely oppose any changes to, or the repeal of the MHRA.
doctor relationship and should not be eliminated just because people who want my data don’t want to ask me for my consent. My medical records and personal information are mine and should remain in my control. I absolutely oppose any changes to, or the repeal of the MHRA.

Sincerely,

Matthew Wagner
Farwell, MN 56327

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To whom it may concern,

My privacy and control in health care are very important to me and many others. Unlike the Minnesota Health Records Act (MHRA), HIPAA is a permissive data-sharing law and does not protect my privacy. I fully support the MHRA which is the strongest health care privacy law in the nation. It requires my consent to share my personal information. My privacy rights are incredibly important to the patient-doctor relationship and should not be eliminated just because people who want my data don’t want to ask me for my consent. My medical records and personal information are mine and should remain in my control. I absolutely oppose any changes to, or the repeal of the MHRA.

Sincerely,

Mark Ziemer
Circle Pines, MN