

## **HF 2294/SF 2093 Conference Committee**

Omnibus HHS Finance Bill

Transcribed by Sam Larson

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**Representative Jim Abeler**- Chair of Conference Committee and Health and Human Service Finance

**Representative Tina Liebling**- DFL Lead on Health and Human Service Reform

**Diane Rydrych**- Minnesota Department of Health

**Mary Krinkie**- Minnesota Hospital Association

**Dave Renner**- Medical Association

**Representative Mary Kiffmeyer**- Vice Chair of Health and Human Service Finance

**Phil Griffin**- Preferred One

**Representative Steve Gottwalt**- Chair of Health and Human Services Reform

[...]

**Abeler:** Let's move to our next topic, which is the patient consent correct? Is the Department of Health here? If they want to come down and ok. Now this is, great, well this is in the bill, this is on the House side. And Ms. Liebling can you tell me where this is in the bill? So people, can, I think there's two parts.

**Liebling:** Mr. Chair it's in article two, sections fourteen and fifteen of the House language.

**Abeler:** Thank you. And while she's coming let me just say, this is provoked by me. I've been part of this record-sharing discussion since we got into record locator services and the whole push for e-records. Currently, in Minnesota law you can get your records released if you have a wet signature authorizing that, if you have a statutory requirement like in work comp. you can get records released, or if someone affirms they have permission. Which is real handy if you're doing that kind of records you can push the 'affirm button' and then off go the records. Already in the system, if you have a record locator service, where records are becoming populated more and more; it will list the various places you've been, what clinics you've been in without any detail. You'll see then you've been to Red Rock Clinic and you've been to you know some maternity center or whatever. Even looking at those titles you can often know what the person has had for care. If it's like Mount Pilot Mental Health Center or orthopedic fix-it back

surgery center or some red door clinic where they do public health services for people who have various needs. That to me is already interesting that, that's known and can be accessed with some, by many, tens of thousands of individuals who have a or are health providers.

What this piece attempts to do is, if you want to get out and access those records you can affirm to have the right to do that. It's easy to have a lot of fraud in that. And there's not any reported because nobody keeps track and you're not notified when your records get accessed. The way electronic records are building it's getting more and more to be the commonplace thing. It's a matter of time until anybody in this room has their records accessed by the boyfriend of some nurse who somebody gave a hundred bucks to and they start to penetrate that safeguards. And it's against the law, it's a crime, but there's no way to know that anybody has checked your records unless you go check on your own records.

If somebody logs on my Facebook, If I log on my Facebook from a different computer I get a little text saying that somebody logged into my Facebook. It's Facebook for heavens sake. But on these records they talk about your pap smears and prostrate situation and how your lungs are, very private data and there's very little safe guard. People lie, sorry to tell you and so people are fraudulent. And my effort in this work has been to narrow it down, who can affirm they have the release of your records. I think there can still be some improvements made, but that's there in the bill. And there's some concerns yet and I respect those, but I think the problem is that we are sitting ducks as a state individuals waiting to have our data accessed. So, that's the challenge, and so welcome to the committee and I did work with you all trying to get some language improved the first version was not nearly as good as the current one. So, could you comment on anything you wanted to comment about then?

**Rydrych:** Certainly, Mr. Chair and members of the committee, for the record my name is Diane Rydrych and I am the Director of the division of health policy at the Minnesota Department of Health. I would say really we're just here to answer questions and we can provide comment if needed. As you noted Representative Abeler, the original language in the bill was substantially different from what we have currently and it would have limited the use of representation of consent to only cases of medical emergencies. Which the department and as number of providers have concerns with because there are already rules related to consent and lack of a need of consent in medical emergencies where the patient by definition is unable to provide that consent. And so upon your request we can provide some technical assistance to address that contradiction in the language and to address your concern that records could be accessed for uses other than treatment which the current language does. It allows the access of, sorry the use of representation of consent for the purposes of treatment payment or healthcare operations. Our intent with providing that assistance was really to acknowledge that the use of representation of consent is certainly much more broad than just cases of emergency. Again those are cases where consent isn't needed. We are in support of a robust system for exchange of clinical information and we are concerned that limiting representation of consent can set us back as a state in doing that, my understanding is that there are concerns still with the current language from providers and payers who, I believe are here to testify about it tonight.

And so I think I would leave it to them to provide more details about their concerns with what the current language does and then we can be here to answer any questions.

**Abeler:** Alright, but if from the Department's point of view if this were to become law in this form you would be neutral on that?

**Rydrych:** We are comfortable with this language and we are comfortable if this language is removed.

**Abeler:** That's fair and I thank you for that. So I think I said it pretty close. Thanks, any questions for the Department? Thanks, for testifying thanks for doing that. And we have an array of witnesses, Mr. Griffin, Ms. Krinkie, Mr. Renner and Ms. Brase. And so, maybe 2 can come at once and offer your advice. Mr. Griffin, welcome to the committee.

**Griffin:** Thank you Mr. Chairman and members of the committee. For the record my name is Phil Griffin, I am representing Preferred One, a nonprofit health plan here in Minnesota owned and operated by Fairview and North Memorial Hospitals and a group of physicians. And I am here at the witness table with Mr. Renner from the Medical Association and Ms. Krinkie from the Hospital Association. And Mr. Chairman with all due respect and members of the committee, Article 2 sections 14, 15, the patient consent for release of records is a provision that still brings concern for our groups and we think for other people. And while we appreciate the chair's explanation of what he is trying to do today, we also do believe **this language will interfere with the ability of organizations like ours to move data in ways that you are asking us to move as we move towards new systems for payment** and Mr. Chairman I don't want to belittle the questions you've raised here on what might be happening and the possibilities. It is impossible for us to prove a negative that nothing bad will ever happen, but I want to committee members to know that the organizations that are in front of you today take very very seriously the privacy of the data that we are working with and work on a constant basis that data is there.

With addition to the concerns that you raised Mr. Chairman I would like to raise concerns that I have individually, about having that data available when needed whether it be an emergency basis or whether it be for some time of new payment system. I'd like my data to be available and moved around and quite frankly I have not seen the examples you have given to us this evening as real threats for the privacy system and in fact I would suggest to the members of the committee and yourself Mr. Chairman that the ability we have for security on medical records currently in the electronic world is much greater than it was on the paper system that existed in years past. Mr. Chairman I won't go into great details beyond that, but let me say the organizations that I am speaking for which includes the Minnesota Council of Health Plans, we believe that this language is unnecessary that **it will interfere with the ability we need to kind of move forward and new kinds of payment systems**, and we would respectfully request these sections be removed from the bill as you move forward. Mr. Chairman I am going to turn to Ms. Krinkie to give you a couple examples of things that are going on with her members.

**Abeler:** Welcome to the committee.

**Krinkie:** Thank you Mr. Chairman and for the record my name is Mary Krinkie and I'm with the Minnesota Hospital Association. I always get nervous when my phone rings at my office and I start hearing from the lawyers who work for my various members and so when they start raising their eyebrows about concerns they have with language I take those concerns very seriously because they don't get concerned about a lot of stuff we do around here, so when I do hear that from the attorneys it makes me pause. I would just like to share a couple examples. I know that our members are doing some very very innovative things right now out in the community coordinating with social services, not just for medical treatment.

So, sometimes we share data once we have patient consent outside of just treatment situations and you may all recall the work that was done last year on the In Reach project, which was found in Owatonna where the hospital worked with Steel County and they worked on social service issues not just medical treatment issues. And we have Regions Hospital located here right in St. Paul has been working on a program hospital to home. And they were finding a large number of folks who perhaps used the emergency room inappropriately they notice this population often times was homeless. And if they could start working with Ramsey County on social services for homeless folks; they could reduce the use of hospital emergency rooms. So, I just mentioned those two innovative programs because we are thinking about how we can use data and information in creative ways to help bend the cost curve. And so we just have to think about the changes as Mr. Griffin said about how we can use data with patient consent we don't want it limited to just medical treatment, operations and payment. I just have one other little example that I just would like to mention. If we don't have patient consent right now we would have to then bill the patient directly and we bill the health plans right now, sometimes without having a patient's signed consent. So, there are times when we proceed with data sharing without having patient consent forms signed and one of those is billing insurance companies. So, thank you Mr. Chairman.

**Abeler:** Well Ms. Krinkie, maybe you haven't seen the new language on 4213 it talks about payment and health care operations, so that's no persuasive to me. And so nobody doesn't want you to get paid, and the interesting thing we can add a term that allows that to be for homeless services or something like that, but what you haven't persuaded me about is fraud. And I don't doubt and Mr. Renner is going to offer some more comments, what I'm happy to hear and he'll get his chance, but you haven't told me about how somebody is going to sneak in there or by virtue of being a dishonest employee is not going to get that data out and give it to somebody for a price. This is going to become valuable some day and in 10 years or 5 years you're going to say Abeler was right. And I'm not being paranoid, I'm just saying how it's going. And so because this data is available, about everything about your history, Ms. Krinkie and it's accessible to a hundred thousand or more people and so that's what I'm after. I'm not worried about what a hospital does and I'm willing to almost exempt hospitals they can take care of their stuff, but I want to find a way that less people who are dishonest has access. I'm not going to get 100% because if I do I'm going to shut down your work. But there has to be

a way to minimize the exposure of these innocent people who have no idea that their data is waiting to be exposed. So, that's your homework assignment, if you want to comment about that you can.

**Krinkie:** Mr. Chairman I don't know that the language that's in the bill as it is now quite matches up with what I think you're trying to get at. So...

**Abeler:** Well this is the best version, I don't like it either that well, but the Department offered it and it seems to address many of the concerns, but I think you have to acknowledge that the problem is there and it's every month you read about some laptop that got left laying around with someone's tax information which is all private locked up somewhere and suddenly it's on a laptop. Somebody would have an access code they would leave laying around and somebody would steal it from them and they would log on and get data out and it's going to be a matter of time, that's all I'm saying. So, you want to know that and it's too expensive to tell people the feedback with a little text message that somebody accessed their data. So, that's the problem, maybe I didn't make the problem clear to you before, but that's what I'm trying to fix. So, you have bright lawyers ask them how to do this. I think you're going to be sorry someday. So, Mr. Renner.

**Renner:** Mr. Chair and members, Dave Renner from Minnesota Medical Association. First of all let me again, I agree with much of what has been said here. I appreciate the problem you are trying to address and I appreciate the changes you've made to the language because earlier versions definitely created some concerns, I still have concerns, however, for similar reasons as Ms. Krinkie when I hear from health law attorneys who are smarter than I who are saying we're not certain if this works. Whenever we get into the issue of medical data and uses of medical records it gets very complicated and what we are concerned with is unintended consequences. I think the issue that you are trying to address is, as I understand is, fraudulent access and fraudulent use of this data.

However, my fear is the language you're putting in here is not addressing the fraudulent use, but instead is limiting potential appropriate use unless it meets one of these three criteria. And again I don't question your motives and your intent or motive and what you are trying to get at but whenever you get into medical records it gets very complex because when you have state laws that may potentially conflict and may create unintended consequences. We share the concern on data privacy with Mr. Griffin said and I think **that the fact that these three organizations are sitting at the table you know we don't see that very often.** I think that's an indication of the concerns we have here with what all fits into the consequences and come out of this language.

**Abeler:** Representative Kiffmeyer.

**Kiffmeyer:** Thank you Mr. Chairman. I take a look at this and recognizing the patient data belongs to the patient, it doesn't belong to the hospital or to the provider. It's the patient's data and that's fundamentally what I see is really important here is protecting that. But I take a look at this and I think of what other uses are you saying you would use this data for because it says here treatment, payment, or healthcare operations. What is missing that would might be an additional word here that would be helpful to you, but I

look at these and I look at the comprehensiveness of this treatment, payment or healthcare operations as anybody here in the room is a patient what else beyond that would you want to use this data for? And maybe that would be helpful to have that answer.

**Abeler:** Yeah whichever one of you can?

**Griffin:** Mr. Chairman, Representative Kiffmeyer. **Let me just back up a little bit and say I'm not sure I agree with your analysis under Minnesota statutes that the medical record belongs to the patient.** Certainly, the patient has access to both clinical and hospital data in their medical record and we've made that very very clear under Minnesota law. But the control of the record really actually belongs with the provider. And that really is something we need to be very clear about. The patient doesn't get to change their medical record with the exception of some very small things that I think we want to make sure we maintain that so the record has the integrity of being a medical record, but the question of what the data gets used for and how it gets used it is not a small question and I think that Ms. Krinkie gave you some ideas of some very innovative projects that are going on, but I can give you examples from one of my other clients which are the FQHCs that work with people in a variety of settings and they're not only healthcare issues, that they're dealing with the social service issues that impact whether or not people actually get healthcare. So, those issues surrounding transportation issues for people trying to move patients back and forth may not be what I call healthcare operations, and I certainly don't think they fall within that. The patient doesn't get to the hospital doesn't get to the doctor, doesn't get that treatment. It doesn't do any good to have the availability of plans or providers or drugs or whatever else we're using in the system.

But if I could go back Mr. Chairman if that answers Representative Kiffmeyer's question, I'd like to go back to your original question and that was the issue of the integrity of the data and making sure that it is kept private and I want members to know that we don't just have computer systems where you have somebody in the backroom making up a quick algorithm and a password that's their birthday or something small like that. We really do work hard making sure we have algorithms that protect the privacy of these systems. That they're constantly changed that they're updated that we are working with the providers that make the kind of software that we use in our computer systems and these are amazing systems as you Mr. Chairman were describing to me that you had the chance to visit one of the local vendors here recently about what they're doing. These are very very complex systems that we are working very hard to make sure that data is protected and the privacy is protected. Is it 100% nobody can never get into it? We all know the kinds of attacks taking place in cyberspace we hear about them in the news. Like it's our government against our military or others. We understand those things are going on and are constantly working with our vendors and with our staff to make sure that they're trained properly and understand this. There are evil people out there Mr. Chairman, you and others have watched me work around here for the last year and a half pro-bono on a case dealing with Mr. Petters the evil one person could perpetrate on society. Those evils has gone into a lot of places and have hurt a lot of people, we can't prevent all evil. And I don't think your language can either, but we can continue to work



together and I hope we will continue to do that, but I don't think that this language gets us there.

**Abeler:** I appreciate that, Representative Kiffmeyer.

**Kiffmeyer:** I want to go back to this fundamental philosophy that, talking about whose data is it. I think you have a duty and a custody without question because it's also the doctor's record of his actions and of his behaviors with a hospital record and I certainly understand that, but you need a signed and dated consent from the patient so obviously there is a situation here that a patient has and as a matter of fact one of the benefits of an electronic record is many times has been a patient getting an access to look at their own record and clarifying any errors that may be on that record either by miscommunication or something like that or for me as a child thinking I was allergic to pears, no I just got the flu after eating pears, nothing to do with pears, pears are fine. They're wonderful, but in my mind's eye I told everybody, 'are you allergic to anything? Yeah pears' ridiculous. Not a huge thing, but they might have even said 'not really', but whatever. But I do think that there is a shared duty and you have custody and responsibility if it wasn't belonging to the patient you wouldn't need a signed and dated consent from the patient, so I just want to make that clear. I think the issue with a comment you made before was that sometimes now the electronic world and the control and the access is sometimes more strict. That's really true, on the other hand, when there is a breach, it's big. And they get a lot more than usual. And so, it is really really important in the electronic world that you do have those security and the parameters around it, but if you don't know securities been breached, you can't really ever correct it. And so again, in this kind of a situation that's what it is for me. I think that what we're trying to do here is come up with that solution and so far, I've heard of the issues of your problems or your concerns, but my specific question is what words could we add to this that would help give you the legitimate scope to do this that you may do legitimate work such as social services or something like that, but I get concerned when it starts becoming so easy and then you go down this slippery slope and the patient is not strong enough to be considered here. So, I know we're going to work on it Mr. Chairman, not going to happen tonight, but I wanted to clarify that.

**Abeler:** Representative Gottwalt.

**Gottwalt:** Yeah I know it's late and I don't want to belabor this too much, but I did want to weigh into say whether we do this language in this bill or not. In the time I have been around here I respect completely for the need for electronic records that's the way we're going, it allows for appropriate access especially when we talk about things like telemedicine and so forth, it's going to be vitally important we have that and I know that providers are setting up secure systems, but what the message typically for the provider community is trust us. If I can kind of paraphrase in really broad terms it's 'trust us, we're doing our best, we've got great systems, trust us'. And I think what I hear frequently is, 'yes, trust us, but this is sensitive data' I think is what Representative Kiffmeyer covered some of it with Representative Abeler. But is there a way can we at least be working on it? You know, some way, I like the idea if somebody accesses my medical record am I notified somehow? Ok, my doc accessed it or somebody in the ER

accessed it and I know about it, that's good. It doesn't seem to me that, that would be that difficult to do. Maybe it would? I don't know. There is this yin and yang between providers owning records and trying to do their best for their patients and still trying to recognize this is sensitive data and the patient's desire to know when it's being accessed. And I don't know where the middle ground is I don't know if this language gets us to that, but I do think we need to have more than just a 'trust us'.

**Renner:** And, Mr. Chairman from the Medical Association point of view I think we would agree with you. As a matter of fact, I think we would argue that our medical record laws is stricter than HIPAAs federal laws because of the concern of the different grades, I don't believe, however that the language that is in this bill does what you ask for it Representative Gottwalt. This doesn't in anyway notify you if somebody's in. So, I think this doesn't deal with what I hear the concern is.

**Abeler:** Mr. Griffin do you want to say something?

**Griffin:** Mr. Chairman I would just reiterate what Mr. Renner said and say that to Representative Gottwalt's point, I'm not asking you to just trust us I'm asking you to work with us to try and find and verify those kinds of things. This isn't the data that we have this is data the state has whether it be related to Medicaid whether is be related to BMAP, we all need to be working together on these kinds of things. And we're certainly not suggesting that you just trust us, but we are working with what we consider to be the best and the brightest in the IT world to come up with these kinds of protections. We have what we think are the best systems available and my client PreferredOne is a beta test for the software vendor that we use, we'd be happy to challenge that system up against what we consider to be antique mainframes and systems that are antiquated in terms of what we're doing. I don't want to say this is something that's just trust us we know what we're doing, but we'd be happy to work with you. My comments to Representative Abeler, he and I met and we spent probably more time than he wanted to discussing this in his office a couple weeks ago. And my poor intern was sitting there watching it like ping-pong going back and forth as she got her education. But, I keep saying that I need to see examples of where the harm is really come down. And while I have heard anecdotes about stolen laptops and some of those things and we use laptops in the systems for lots of things that whether it be the nurse practitioner that's at the assisted living facility with my mother when I went there yesterday or whether it's people doing auditing that come in to do our books and move laptops around. But those systems we also make sure are secured. And that there are algorithms on that data and if the laptop is stolen, somebody opens it up and hacks into it they can't get into it and if they do get into it they get the data they can't use.

**Abeler:** And just to, there's one more witness, but just to this and then you guys can go. No ones concerned about the health plans office, but I'm concerned about a health plan angry employee or somebody for some kind of game, be it money sometime or some other benefit is going to not hack in, they're going to access using their code and no one is going to know for a year that they've got your data about your health plan about your information there's no way to know and they use the company computer perhaps, but



now they log on from home out of this site or our clinic has pretty mediocre equipment at my clinic we just not impressive, but it works for our work. Low-tech you worry about the low-tech sites, the nursing homes, some of the providers who are here who are doing home care stuff have an access right to get some of this stuff. That's what I'm worried about. Not you guys, so then that's the problem I'm bringing to you. So, I don't know this may not be the answer, but I was to be able to make you own the problem. And so when you come here and when you talk us out of having some safeguards and later it happens, then the people who denied the problem will be the ones who have to own it. I'm just telling you that. So, we'll talk some more.

Ms. Brase, do you want to come down? So, help me out here if you can. And then we're going to talk about fees next, so if anybody wants to stay for that. Ms. Brase, welcome to the committee. Hope you enjoyed the discussion.

**Twila Brase:** Yes, Mr. Chair. This is Twila Brase, I'm President of Citizens Council for Health Freedom and have done a whole lot on the privacy issue over the years and know a lot about what Representative Abeler is talking about, so I'm going to just say, I have three little sections here.

The first section is just to talk about the language in the bill and the second is just to adjust what you have said. And we do appreciate your comments; we do appreciate Representative Abeler's concerns in his comments. The thing about the language in the bill that I'm going to point out a few things here.

One, representation for anyone who happens to be listening to this and doesn't understand representation isn't actually a signature, it's just a representation that someone's got a signature.

The second thing is there's no definition for payment treatment for healthcare operations, I'll bet that everyone here thinks they have some idea on what that is, but the fact of the matter is there is no definition, what we do know is there is a definition for payment treatment operations in HIPAA which we call the 'no privacy law' and the payment and the treatment in healthcare are broader than anybody actually thinks. As a matter of fact healthcare operations is I believe, if I recall correctly, 306 words long and every part of that definition could have another definition under it, explaining each one of those things that are in the definition, so it seems to us that you are bringing in as much as I understand what you're trying to do.

It does seem to us you are bringing in what we consider controversial HIPAA language and we do indeed have stronger language here in Minnesota than in the federal law, so by bringing this in we're not comfortable with that.

There is also nothing to require patients to know what they're signing because they have their own idea too about what payment treatment for healthcare operations there is again no definition. So, that's the language part.

Now, I found Mr. Griffin's comments interesting, in particular, and so I thought I would give a few little facts here from some studies namely that a variety of studies, eighty percent of healthcare organizations have reported one or more breaches. Most breaches are inside jobs. The HHS reported I believe it was 7.2 million breaches over a two-year period and the latest statistic, I believe it was in January it cost 7.2 million dollars per incident. In addition to that you may recall that in January the Attorney General here sued Accretive which was a contractor of Fairview for the fact they had lost the computer with 23,500 patients in it and her lawsuit alleges they gained access to this sensitive data through contracts with the hospitals and numerically scored patients risk of hospitalization and medical complexity, graded their frailty, compiled per patient profit and loss reports, and identified patients deemed to be outliers. This debt collector, which is who they are, found ways to essentially monetize portions of the revenue and healthcare delivery systems of some nonprofit hospitals for Wall Street investors without the knowledge or consent of patients who have the right to know their information is being used said Attorney General Swanson.

So, that's the third part and I do have to say, I think it's very interesting that Mr. Griffin said that our security is better today with electronic than it is with paper because I would love to see how people would take 23,500 records out of somebody's office and cart them away so readily as they can on a laptop.

So, the third part I want to talk about is just trying to get you to your goal, Representative Abeler. And, so I recall language did talk about, 'in an emergency' and we've never liked this section, we've never liked the representation, but we know why people have electronic medical records in their systems like that. So, we would have preferred at that point in a documented emergency and at the end it would have said, solely for current treatment. So, that would be the only reason why there would actually be a release under representation and we thought that release should be documented for the patient the they know what happened and by whom and so you could also add language that says the details of this release shall be documented and shared with the patient and that way the patient will actually knows what's happening.

Another idea of course is to require consent for online interoperable electronic medical records, so like some other states do which would also help you deal with what you are trying to get at and another one which I think that the health plans or the hospitals haven't talked a lot about, but if any of you have been to your doctors as of late, you may realize there's about nine things you're consenting to with one signature and we find that very problematic. And most individuals aren't going to know and they're going to sign it and they're going to allow all these social services and everything else to happen.

And finally to get to your idea about people should know, back in the record locator service day in 2007 we actually tried to get a requirement that patients could get access to the access log and were unable to get it. And we still think that should occur, so those are my comments, Mr. Chair.

Abeler: Well thank you; I like the access log idea. I've given up on the consent thing, I tried in 2007 and I appreciate that. Any questions for Ms. Brase? It's late, but I appreciate your comments, so thank you.

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**1:23:50**

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