REPORT ON ECONOMIC IMPACT OF HHS PROPOSAL TO ADOPT 42 C.F.R. § 164.524(d) AND APPLY THE FEDERAL PATIENT RATE TO THIRD-PARTY DIRECTIVES

Finalization of the HHS proposal would create a shift in costs, which could exceed $1 billion, from commercial third-party requesters to hospitals, physician groups, and other outpatient service providers.

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1. EXECUTIVE SUMMARY

The U.S. Department of Health and Human Services ("HHS") has issued a Notice of Proposed Rulemaking ("NPRM"), containing a Proposed Rule entitled Proposed Modifications to the HIPAA Privacy Rule to Support, and Remove Barriers to, Coordinated Care and Individual Engagement, 86 Fed. Reg. 6,446 (Jan. 21, 2021). The Proposed Rule would, among other things, add new regulatory text at 42 C.F.R. § 164.524 that would require covered entities that respond to patient directives and send protected health information ("PHI") in electronic health records ("EHRs") to life insurers, law firms, and other third-party requesters using that information for commercial purposes ("Commercial Third-Party Requesters") to charge the Patient Rate for those third-party directives ("TPDs"). The Patient Rate is a low, federally-mandated rate for patient requests for individual use.[1] While HHS estimates that adding the new regulatory text would yield net cost savings, HHS seeks comment on the potential unintended consequences of implementing the proposed changes.[2]

This report sets forth the analysis by Hemming Morse, LLP ("Hemming Morse"), of the provisions of the Proposed Rule that would add new regulatory text at 42 C.F.R. § 164.524. Hemming Morse has conducted its analysis for the Association of Health Information Outsourcing Services ("AHIOS").[3] AHIOS's members are release of information companies ("ROI" and "ROI Companies") that support health care providers by fulfilling requests for the release of PHI on their behalf. In making its analysis, Hemming Morse has performed an investigation of operational data maintained by AHIOS members, including an anonymized survey of members, the methodology of which is described in Appendix B.

Historical experience and available data show that the single greatest economic effect of the new regulatory text would be a shift in the costs of fulfilling requests for PHI in EHRs from the Commercial Third-Party Requesters that currently pay for those requests, to the health care providers that respond to the requests or engage ROI Companies to handle them. This type of shift has happened before, and HHS assumes that it would happen under the Proposed Rule, based on the logical expectation that those who currently pay for requests will use a new available mechanism to reduce their costs by over 95%. HHS, however, greatly underestimates the quantum and effect of the shift. The cost shift to hospitals and outpatient service providers such as physician groups and clinics, resulting from the dramatic decline in the rates that can be charged, could exceed $1 billion annually.

For HHS, the significant cost shift onto health care providers would be an unintended consequence of requiring that health care providers charge the Patient Rate when fulfilling patient directives to transmit PHI in EHRs to Commercial Third-Party Requesters:

- Health care providers outsource to ROI Companies partly because it is cost-effective; ROI Companies cover most of their operating costs through the fees they collect from Commercial

[1] NPRM, pp. 6447-6448, 6536-6537.
[2] NPRM, pp. 6505-6509, 6468, 6470 ("The Department seeks … [m]ore information from covered entities … about their experiences with record requests (including when made at the direction of the individual …) and any unintended consequences that may result from the Department's proposals.").
[3] Hemming Morse performs financial, accounting, and economic investigations and was engaged by AHIOS to perform this study, with access to confidential AHIOS member data not shared between members. The Hemming Morse team is led by Christian Tregillis and Jeffrey Klein, and their work has been performed in compliance with standards promulgated by the American Institute of Certified Public Accountants. A summary of the qualifications of Mr. Tregillis and Mr. Klein are attached at Appendix A, and their methodology and materials and information considered are set forth in Appendix B.

Third-Party Requesters. The value proposition is so strong that nearly 80% of hospitals nationwide and numerous other providers outsource this function to ROI Companies.

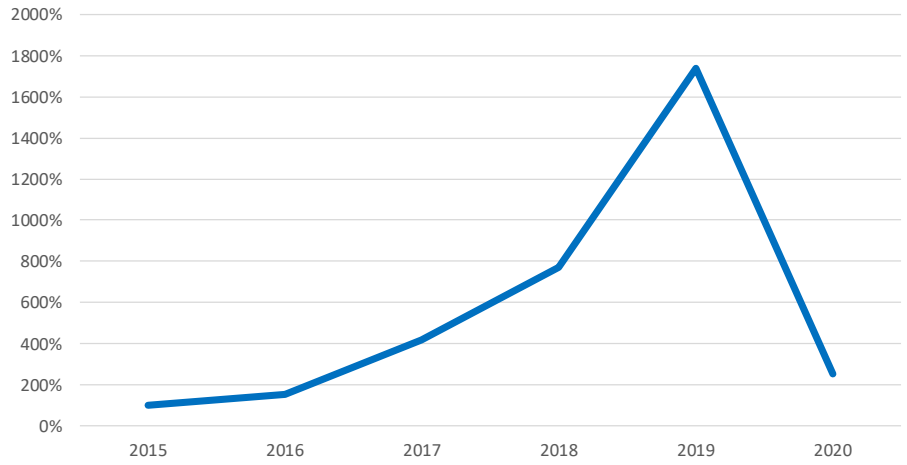
- Federal or state law may dictate what providers and their ROI Companies may charge to fulfill requests for PHI by patients or their providers. Even when the law authorizes a fee, many providers and their ROI Companies choose to give patients or their providers access to PHI for free because it enables the delivery and coordination of patient care.

- Currently, Commercial Third-Party Requesters make access requests for PHI using patient authorizations or TPDs, and pay rates for the fulfillment of those requests that are determined by the states or through contract negotiations. Under state law, health care providers and their ROI Companies typically charge higher rates for such commercial third-party requests (which do not enable the delivery or coordination of care) than requests to send PHI to a patient or for coordination of care. The higher rates cover the costs of fulfilling the commercial third-party requests *and* cross-subsidize the fulfillment of requests related to patient care.

- The finalization of the Proposed Rule would apply the federal Patient Rate to TPDs for PHI in EHRs, which would likely cause Commercial Third-Requesters to jump to TPDs at the Patient Rate to the point of disabling the subsidy. The jump to TPDs at the Patient Rate would likely disable the subsidy because 84% of the records produced to Commercial Third-Party Requesters in response to access requests come from EHRs. The percentage is far higher than HHS has estimated, and is rising as more records shift to electronic systems. In addition, the federal Patient Rate is much lower than what Commercial Third-Party Requesters currently pay.

- Past experience and data, and HHS's own assumptions about requester behavior, are consistent with our view that Commercial Third-Party Requesters will jump to TPDs at the Patient Rate, and shut off the revenue that cross-subsidizes the fulfillment of requests related to patient care. In 2016, HHS issued its access guidance that gave Commercial Third-Party Requesters a pathway for accessing the Patient Rate through TPDs. Seeing this as an avenue for cost reduction, even without adoption of a law by Congress or notice-and-comment rulemaking by HHS, TPDs from Commercial Third-Party Requesters increased. The trend reversed only after a federal court in *Ciox v. Azar* vacated the 2016 access guidance in January 2020. The following chart shows the impact on TPD volume for one AHIOS member:

Figure 1. Patient Directed Requests, 2015-2020 (Indexed to 2015): AHIOS Member #5



Source: Company accounting records. Not all AHIOS memebrs tracked these requests separately. In addition, some had none of these requests prior to 2016, so the percent increase is infinite.

HHS recognizes in its cost-benefit analysis in the NPRM that Commercial Third-Party Requesters will jump to TPDs at the Patient Rate, with the HHS analysis assuming that TPDs at the Patient Rate will be as much as half of all access requests directing PHI to Commercial Third-Party Requesters. But HHS underestimates the extent of the jump (perhaps because HHS lacks critical data), as well as the effect.

- If Commercial Third-Party Requesters make the economically rational decision to jump to TPDs at the Patient Rate and save substantial amounts of money, then the ROI Companies that handle the requests for health care providers will likely experience substantial drops in revenue that make it impracticable to operate under their current business model. ROI Companies would have to transition to a new business model (whereby they would charge health care providers a fee per transaction, which health care providers could not pass on to Commercial Third-Party Requesters), or exit the market and leave health care providers to service these requests on their own. If ROI Companies were to exit the market and providers were to fulfill ROI requests themselves, that would add both substantial compliance risk (given the complexity of fulfilling requests) and substantial financial risk (as the new Patient Rate fees paid by Commercial Third-Party Requesters would not come close to covering the cost of fulfilling these requests). The disruption of the market would have the greatest financial and operational impact on small providers, which have fewer administrative resources and lack economies of scale.

- Any jump to TPDs at the Patient Rate will probably include an increase in the volume of records sought by Commercial Third-Party Requesters. History shows that when Commercial Third-Party Requesters have to pay for their requests, they limit the size of their requests, but when they can get those records for free or close to free, the size of the requests increases greatly. For example, in 2018, when the 2016 access guidance was effective, the average TPD for Commercial Third-Party Requesters for the ROI Companies investigated was 229 pages, based on data from an AHIOS member. By comparison, the same type of requests were billed and paid at the state-law-defined rate and were 69 pages on average (less than 1/3 the length). In sum, when the same type of requests were free or almost free, they became over three times as large. Larger requests create additional privacy and security risk with more information disclosed than is needed.

- If health care providers bring ROI operations in house and cannot cost-effectively outsource to ROI Companies as they do today, then the overall cost of healthcare in the U.S. will almost certainly increase. Increased costs would likely flow through to patients.

Industry experience and data, basic economic reasoning, and HHS's own assumptions about requester behavior all suggest that finalization of the Proposed Rule would prompt Commercial Third-Party Requesters to jump to TPDs at the Patient Rate, upend the cross-subsidization that enables ROI Companies to release PHI directly to patients and health care providers for free or nearly free, and force ROI Companies to transition to a fee-for-service model for outsourced fulfillment of PHI requests or otherwise exit the market. This would dramatically increase health care costs in the United States as well as the risk of mishandling of PHI.

2. FACTUAL BACKGROUND

a. THE ROI PROCESS IS COMPLEX AND BURDENSOME FOR PROVIDERS.

The ROI process involves the release of PHI to an individual or other party authorized to receive or review the PHI. It is complex to manage because requesters and requests for PHI vary, providers

maintain PHI in different formats and systems, operations must comply with a patchwork of federal and state laws, and errors present enforcement and reputational risks.

Requesters of PHI include numerous parties, besides individual patients, who may have an interest in using the information for purposes, such as continuity of care, billing, life insurance underwriting, audits, risk-adjustment analysis, research, or litigation (attorneys), among many others. These requesters can be grouped into the following five categories.

1. Patient-to-Self - Requests by patients or someone who stands in their place
2. Continuity of Care - Requests by or for health care providers, relating to patient care
3. Commercial - Requests related to life insurance policy underwriting, property insurance, casualty insurance, workers compensation insurance, law firms/litigation, and others
4. Commercial Review/Audit - Risk adjustment and similar related reviews, such as for Healthcare Effectiveness Data and Information Set ("HEDIS") testing of health plan business performance
5. Other - Requests do not fall within the above categories and include billable and non-billable requests, such as government requests, state disability, and vocational rehabilitation centers.

As explained in Section 3 of this report estimating the cost shift that would likely to result from implementation of the proposed changes, costs associated with categories 3 and 4 are estimated, though the likelihood of these costs being shifted differs between these categories.

Broadly, the processing of a request for PHI involves five types of tasks: (a) logging, tracking, and verifying information, (b) retrieving PHI, (c) protecting sensitive information, (d) releasing authorized information, and (e) completing and invoicing the request. The many detailed steps for each task are summarized in the AHIOS chart attached at Appendix C.

Before the advent of ROI Companies, health care providers handled all of these tasks in-house, and often delegated work to staff with other responsibilities. The in-house model was problematic because the handling of PHI can be laborious, costly, and risky. The demand for a compliant, cost-effective, and efficient solution was met by ROI Companies. The value proposition of ROI Companies has proven so strong that, over time, nearly 80% of hospitals nationwide and many outpatient providers have outsourced tasks—especially high-risk tasks—to ROI Companies.

ROI Companies enable health care providers to mitigate risk, reduce costs, and streamline operations through the use of customized information systems and other business tools. The business tools relieve providers from the burden of monitoring regulatory developments, align the work flow with applicable federal and state laws and regulations, and automate and enable the tracking and documentation of numerous steps in the ROI process. ROI companies are able to spread the costs of developing, testing, implementing, and regularly updating the customized tools across all of their customers. The systems that ROI Companies maintain are for the specific purpose of evaluating, processing, and delivering on record requests with functionality that is not generally available in most EHRs and systems, particularly relative to determining which segments of a medical record are permissibly transmitted as a matter of patient permission and law to fulfill such requests.

For example, AHIOS member #5 maintains over 1,000 rate matrices to operationalize the rules that dictate the appropriate fees for fulfilling PHI requests, based on criteria such as the type of records requested (*e.g.*, x-rays), the purpose of the request, the jurisdiction, whether the requestor is a non-

government person, whether the requestor is receiving public legal assistance, and whether the records to be delivered are a first copy (as opposed to a second request for the same records), among others. The following is a sample matrix for the State of Minnesota and its rules, as of March 2021:

Minnesota

Rates	Page Fee	Retrieval Fee	Shipping Fee	Sales Tax	Note	Legal Reference
Physician	None	None	None	None		
State	1+ @ 1.44 per page	19.19	USPS	None		MN S. 144.292 Subdivision 6
Disability	None	35.00	None	None		State Sets Rate
State Social Security	None	10.00	None	None	*	
Workers Comp (WC)	1+ @ 0.75 per page	10.00	USPS	None	**	Dept of Labor & Industry 5219.0300 subp 2
Vocational	None	15.00	None	None		State Sets Rate
No Records Statement	None	19.19	USPS	None		
Cancellation Fee	None	19.19	None	None		

This information is constantly updated, for each state and federal rules, for all types of requests. ROI Companies typically have a quality control team member keep track of this information, make updates, and integrate the matrix into the company's information systems and processes across all health care providers for which the ROI Company fulfills requests.

The information systems developed by ROI Companies are highly customized. They include robust PHI delivery capabilities that are not available in off-the-shelf information systems, including Secure File Transfer Protocol (SFTP), Application Programming Interface (API) delivery, and web-based download. SFTP enables ROI Companies to aggregate requests and records for large volume requesters (*e.g.*, health plan auditors), and then upload and deliver the records in an efficient, secure manner. API delivery enables ROI Companies to maintain an integrated connection with government systems, which further automates the fulfillment of requests for PHI by governments. Web-based downloads create similar efficiencies by further automating the fulfillment of aggregated requests submitted by records retrieval companies, while also providing a modern user experience for patients and record requesters, a functionality that is not available in most EHR systems.

Customized information systems and compliance tools are developed only through substantial and continuing investments of money and time. ROI Companies can bring those tools to market because they can recover their investments by fulfilling requests for PHI on behalf of multiple health care provider customers, such as hospitals and doctor groups. It would be impossible for individual providers to fund and manage the same development process while simultaneously fulfilling requests for PHI and delivering care to patients, which has driven providers to outsource management of the ROI process to ROI Companies.

b. HISTORY SHOWS THAT COMMERCIAL THIRD-PARTY REQUESTERS JUMP TO TPDs AT THE PATIENT RATE TO SAVE MONEY.

The TPD is a relatively new mechanism for obtaining PHI from providers. Congress did not contemplate the TPD when it enacted the Health Insurance Portability and Accountability Act of

1996, Pub. L. No. 104-191, 100 Stat. 2548 (2016) ("HIPAA"). Neither did HHS when it issued its final "Privacy Rule" implementing HIPAA.[4] The Privacy Rule recognizes the right of individuals to access PHI, and originally prohibited covered entities from releasing PHI stored in any format to a third party without a "valid authorization."[5] The Privacy Rule also established the permissible fees that can be charged for productions of PHI.[6] For requests brought by an individual seeking their PHI—known as a "personal use request"—the Privacy Rule permitted a covered entity such as a health care provider to charge a "reasonable, cost-based fee," known as the "Patient Rate."[7] The Privacy Rule further permitted "covered entities" to recover through the Patient Rate the costs of "[c]opying, including the costs of supplies and for labor for copying, the [PHI]."[8] The Privacy Rule did not "affect the fees that covered entities charge for providing [PHI] to anyone other than the individual."[9] Under the Privacy Rule, covered entities and their ROI Companies were free to charge state-regulated and contractual rates to Commercial Third-Party Requesters of PHI.[10]

Congress changed HIPAA when it enacted the Health Information Technology for Economic and Clinical Health Act, Pub. L. No. 111-5, Title XIII, 123 Stat. 115, 226 (2009) ("HITECH Act"). The HITECH Act created a new individual right to direct a covered entity to produce an electronic copy of PHI in an EHR to a third party of the individual's choosing.[11] In other words, the HITECH Act created the TPD mechanism.

The HITECH Act mandates that the fee that a covered entity may charge an individual for an electronic copy of PHI sent to the individual "shall not be greater than the entity's labor costs in responding to the request."[12] The HITECH Act, however, does not authorize limits on the fees the covered entity may charge when it sends an electronic copy to a third party.

After Congress enacted the HITECH Act, HHS amended the Privacy Rule by issuing a new rule named the "2013 Omnibus Rule."[13] The 2013 Omnibus Rule extended TPDs to PHI in any format. It also clarified that the Patient Rate for individual requests "could include skilled technical staff time spent to create and copy the electronic file," but would exclude "actual labor costs associated with the retrieval of electronic information" and "fees associated with maintain systems and recouping capital for data access, storage, and infrastructure."[14] The extension of TPDs to PHI in any format correlated with a modest, incremental uptick in the use of TPDs from 2013 through 2015.

HHS then issued its 2016 access guidance, which purported and sought to extend the Patient Rate to TPDs for PHI in any format. Up until that point, covered entities had charged state-regulated and contractually-negotiated fees for TPDs instead of the much lower Patient Rate. The drop to the Patient Rate, without Congress adopting a law amending HIPAA or notice-and-comment rulemaking by HHS, led to a dramatic increase in TPD usage of over the next three years. Some AHIOS

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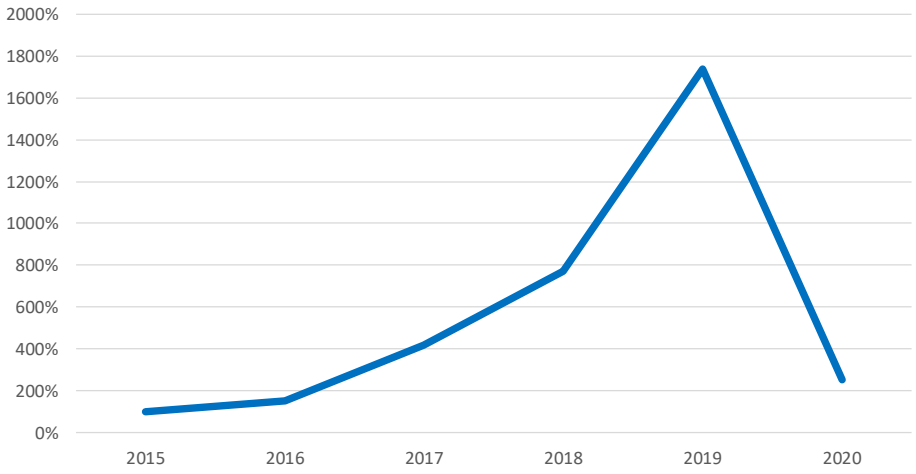
[4] *See* Standards for Privacy of Individually Identifiable Health Information, 65 Fed. Reg. 82,462 (Dec. 28, 2000) (codified at 45 C.F.R. § 164 *et seq.*).
[5] 45 C.F.R. § 164.502(a)(1)(iv).
[6] *See* generally 45 C.F.R. § 164.524.
[7] 45 C.F.R. § 164.524(c)(4).
[8] 45 C.F.R. § 164.524(c)(4)(i).
[9] 65 Fed. Reg. at 82,577.
[10] 65 Fed. Reg. at 82,577.
[11] 42 U.S.C. § 17935(e)(1).
[12] 42 U.S.C. § 17935(e)(3).
[13] *See* Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules Under the [HITECH] Act and the Genetic Information Nondiscrimination Act; Other Modifications to the HIPAA Rules, 78 Fed. Reg. 5,566 (Jan. 25, 2013).
[14] 78 Fed. Reg. at 5,636.

members had no TPDs before 2016, and saw TPD usage run up quickly after issuance of the 2016 access guidance. For example, AHIOS member #5 saw its TPDs increase by over 1600% after the 2016 access guidance, but then fall dramatically after the district court in *Ciox Health v. Azar*, 435 F.Supp.3d 30 (D.D.C. 2020) vacated the 2013 Omnibus Rule and the 2016 access guidance under the Administrative Procedure Act.[15]

Figure 1. Patient Directed Requests, 2015-2020 (Indexed to 2015): AHIOS Member #5



Source: Company accounting records. Not all AHIOS memebrs tracked these requests separately. In addition, some had none of these requests prior to 2016, so the percent increase is infinite.

The responses of Commercial Third-Party Requesters to the 2016 access guidance and the *Ciox* decision show that the requesters are rational economic actors that will jump from submitting direct requests with patient authorizations or TPDs at higher rates, to leveraging TPDs at the lower Patient Rate, when HHS creates a regulatory pathway for them to do so. The 2016 to 2020 experience show that where there is a perceived opportunity to obtain requested records for a lower price, requesters will try to obtain the lowest price possible.

The lengths to which these requesters go in their efforts to lower the cost they pay for PHI is not constrained by HIPAA, and in some instances these requesters argue with health care providers and other covered entities about what rate applies. For example, AHIOS member #9 has received requests from courts to be charged the Patient Rate for records requested via subpoenas: a category not subject to the Patient Rate. Similarly, AHIOS member #3 has received requests from health plan auditors to have record requests fulfilled at the Patient Rate, even though this too is a category not subject to the Patient Rate. In addition, health care providers and their ROI Companies currently fulfill, free of charge, many record requests for which they are able to charge a Patient Rate (e.g., for a Patient-to-Self request). ROI Companies keep data that show how Commercial Third-Party Requesters are frequently able to push health care providers' in-house record request fulfillers to process requests for an average of 40% off of the rates that ROI Companies are able to charge and collect, but even ROI Companies are pushed hard by these requesters.

HHS assumes in the NPRM that Commercial Third-Party Requesters will jump to TPDs at the Patient Rate to achieve the lowest price possible for PHI. Specifically, HHS assumes that, of the 2.46 million requests processed each year (an HHS estimate), the volume of access requests will be 1,230,000

[15] The *Ciox* court vacated 1) the 2013 Omnibus Rule insofar as it expanded the HITECH Act's TPD to include all PHI beyond that maintained in an EHR, and 2) the 2016 access guidance to the extent it "extend[ed] the Patient Rate to reach third-party directives."

(50%) individual patient requests seeking direct access to PHI, 615,000 (25%) requests directing PHI to hospitals and health plans, and 615,000 (25%) requests directing PHI to third parties besides hospitals and health plans (which would include TPDs for PHI in EHRs). HHS sets forth its assumption in Table 6 of the NPRM, shown below.[16]

TABLE 6—ESTIMATED NUMBER OF ANNUAL ACCESS REQUESTS, BY RECIPIENT

Recipient of PHI copies	Number of access requests
Individuals	1,230,000
Health Care Providers and/or Health Plans	615,000
Third Parties other than Providers and/or Plans	615,000
Total	2,460,000

Of an estimated 2.46 million annual access requests, the Department assumes that 50 percent (1.23 million) are for individuals to directly access PHI, 25 percent (615,000) direct copies to health care providers or health plans, and the remaining 25 percent (or 615,000) direct copies to other third parties, as indicated in Table 6.

As explained below, HHS's assumptions regarding the volume of third-party access requests—particularly TPDs for PHI in EHRs—are inconsistent with the experience of ROI Companies that process these requests and would be affected by finalization of the Proposed Rule.

c. THE PROPOSED RULE IS BASED ON A COST-BENEFIT ANALYSIS UNDERTAKEN WITHOUT THE ADVANTAGE OF ROI COMPANY EXPERIENCE AND A MISTAKEN UNDERSTANDING OF APPLICABLE RATES.

The purpose of the rulemaking is to "address standards that may impede the transition to value-based health care by limiting or discouraging care coordination and case management communications among individuals and covered entities (including hospitals, physicians, and other health care providers, payors, and insurers) or posing other unnecessary burdens." 86 Fed. Reg. at 6446. The rulemaking seeks to "address these burdens while continuing to protect the privacy and security of individuals' protected health information." *Id*. To that end, HHS would add regulatory text at 45 CFR § 164.524(d)(7) that enables the use of TPDs, plus regulatory text at 45 CFR § 164.524(d)(6) that applies the Patient Rate to TPDs. 86 Fed. Reg. at 6447, 6537.

HHS projects that these changes will create annual "cost savings" for covered entities (*e.g.*, health care providers) that are borne by individuals or third-party requesters. *Id*. at 6508. That is, HHS projects that the changes from the Proposed Rule will benefit covered entities by generating a net *increase in the ROI fulfillment revenues* received from individuals and third-party requesters. *See Id*. at 6506. The net increase will supposedly occur because covered entities will charge significantly more for requests for PHI in non-electronic (*e.g.*, paper) and non-EHR electronic formats (from systems that predate EHR systems), to a level that eclipses the revenues lost by charging the Patient Rate for TPDs accessing EHR records. NPRM, pp. 6508, 6519.

HHS uses two different methodologies to project the cost savings. Methodology 1 produces three alternative projections of the cost savings by assuming that all access requests directing PHI to Commercial Third-Party Requesters are requests for "hybrid records" containing PHI in two different formats. Methodology 2 produces another alternative projection of the cost savings by assuming that half of all access requests directing PHI to Commercial Third-Party Requesters are TPDs for

[16] NPRM, p. 6506.

PHI in EHRs, and half are requests for PHI in hybrid records. Together, Methodologies 1 and 2 yield a total of four alternative projections of the cost savings.

Methodologies 1 and 2 incorporate estimates about the "allowable fees" for records under the Proposed Rule, state law, and the "current rule." HHS estimates the fees for 100-page records in Table 9 of the NPRM, with $1.41 reflecting HHS's estimate of what the Proposed Rule would permit as a fee for a request comprising 100 electronic pages.[17] In contrast, the estimated allowable fees under state law for the same 100-page request are assumed by HHS to be $76.70, while the estimated allowable fees for the same 100-page request under the "current rule" are $8.49. While the figures referenced above relate to a 100-page electronic record, other figures in Table 9 relate to requests for non-electronic records under state law ($88.16) and the current rule ($16.74).

TABLE 9—ESTIMATED FEES FOR COPYING AND SENDING A 100-PAGE RECORD TO A THIRD PARTY

Estimated allowable fees for 100 non-electronic pages under state law	Estimated allowable fees for 100 electronic pages under state law	Estimated allowable fees for 100 non-electronic pages under the current rule	Estimated allowable fees for 100 electronic pages under the current rule	Estimated allowable fees for 100 electronic pages under the proposed rule
$88.16	$76.70	$16.74	$8.49	$1.41

HHS estimates the allowable fees for a 200-page hybrid record (100 electronic pages and 100 non-electronic pages) as summarized in Table 8 of the NPRM, with a total of $25.23 allowable fees[18] under the current rule and $133.50 under state law.[19]

HHS does not explain how it calculated the estimated allowable fees under the "current rule." Moreover, the "current rule" conflicts with the HITECH Act, *Ciox*, and industry practice by assuming that the 2016 access guidance remains effective and covered entities are still charging the Patient Rate for access requests directing PHI to third parties. We discuss the "current rule" here without accepting it as the current state of the law or the industry.

In addition, HHS does not identify the source of its estimates of allowable fees under state law of $76.70, $88.16, and $133.50, or explain the math underlying those estimates.

HHS incorporates its estimated "allowable fees" into Methodologies 1 and 2, as follows:

- Methodology 1 purports to analyze a "200-page" hybrid record request directed to a third party using a baseline HHS estimate of $25.23 of "allowable fees" under the current right of access,"[20] with three alternative calculations falling under this methodology.
    - Alternative 1: HHS assumes that all 615,000 access requests would be for 100 pages of non-electronic and 100 pages of pre-EHR electronic records ("electronic records not in an EHR"), resulting in increased allowable fees and "cost savings" of $66.59 million (615,000 x ($133.50 - $25.23)).[21]

[17] NPRM, p .6507.
[18] NPRM, p. 6507. $25.23 is the sum of $16.74 and $8.49, from Table 9.
[19] NPRM, p. 6507.
[20] NPRM, p. 6508.
[21] NPRM, p. 6508.

- Alternative 2: HHS assumes that for the 615,000 access requests, these requests would be for 100 pages of pre-EHR electronic records and 100 pages of EHR records,[22] resulting in $32,57 million in "cost savings" (615,000 x (($76.70 + $1.49) - $25.23))).[23]

- Alternative 3: HHS assumes that for the 615,000 access requests, these requests would be for 100 pages of non-electronic records (*e.g.*, paper), resulting in $39.62 million in "cost savings" (615,000 x (($88.16 + $1.49) - $25.23)).[24]

- Methodology 2 (HHS's fourth alternative calculation) assumes that 50% of HHS's estimated 615,000 annual access requests (307,500) "*would no longer* fall within the right of access," resulting in "cost savings" of $33.29 million (307,500 x ($133.50 - $25.23)), offset by increased costs of $2.15 million due to reductions in "allowable fees" for the other 307,500 requests (307,500 x ($8.49 - $1.49)).[25]

Under Methodology 2, HHS assumes that 307,500 of the 615,000 access requests directed to third parties are for hybrid records containing non-electronic and pre-EHR electronic records that "would no longer fall within the right of access" after finalization of the Proposed Rule. As an initial matter, under the HITECH Act and *Ciox*, access requests for non-electronic and pre-EHR electronic records are not TPDs within the right of access.[26]

HHS "seeks comments on these estimates, averages, and assumptions underlying its analysis and invites comments on the number and type of access requests received by covered entities, costs incurred, and fees charged,"[27] with HHS also seeking comment on "any unintended consequences that may result from [its] proposals."[28]

The HHS analysis suffers from several problems that render its estimated "cost savings" flawed. First, HHS underestimates the number access requests directing PHI to third parties, including the number of TPDs for PHI in EHRs. Second, HHS assumes that covered entities are currently charging the Patient Rate for all access requests directing PHI to third parties, when they are in fact charging the higher state rates permitted by law, in the wake of *Ciox*. Third, HHS assumes that when covered entities fulfill requests for PHI in pre-EHR electronic formats or paper, they will migrate to charging state rates that do not appear to be tethered to any particular state. The end result of these problems is that HHS finds "cost savings" where none exist, and fails to appreciate that the finalization of the Proposed Rule would apply the Patient Rate to a much larger number of access requests.

HHS underestimates the access requests directing PHI to third parties

As noted above, HHS estimates that the total volume of access requests is 2.46 million annually. Of those access requests, HHS estimates 1,230,000 (50%) *individual* patient requests seeking direct

[22] HHS describes this as "a Request … for 100 Electronic Pages That are not in an EHR and 100 Electronic Pages That are in an EHR."
[23] NPRM, p. 6508.
[24] HHS describes this as "a Request … for 100 Non-Electronic Pages and 100 Electronic Pages That are in an EHR.
[25] NPRM, p. 6508 (emphasis added).
[26] *Ciox*, 435 F.Supp.3d at 64-66 ("The Act says nothing about a right to transmit PHI contained in any format other than an EHR. This plain text limitation prompted HHS to observe during the rulemaking process that § 17935(e) 'applies by its terms only to [PHI] in EHRs.'").
[27] NPRM, p. 6508.
[28] NPRM, p. 6470.

access to PHI, for themselves, 615,000 (25%) requests directing PHI to *hospitals and health plans*, and 615,000 (25%) requests directing PHI to *third parties besides hospitals and health plans*.

HHS's estimate of 2.46 million annual requests is too low. HHS made its estimate by assuming "that in one year one-tenth of a percent of health care encounters with health care providers results in an access request," but HHS does not explain why it was reasonable to assume one-tenth of a percent as opposed to some other percentage.[29] HHS states that it "received wildly varying reports from covered entities that commented on the RFI regarding the number of access requests they receive annually."[30] As discussed later in this report, AHIOS member data show that there are far more requests processed each year than estimated by HHS.

HHS's estimate of 615,000 (25%) requests directing PHI to third parties besides hospitals and health plans is also too low. This is apparent when the HHS categories of requests are compared to the most similar AHIOS categories of requests. Under the AHIOS categories, Commercial requests are 35.0% of the total requests for the Patient-to-Self, Continuity of Care and Commercial categories.[31] The percentage of Commercial requests (35.0%) under the AHIOS categories exceeds the percentage of requests directing PHI to other third parties (25.0%) under the HHS categories by 10%:

Figure 2. Relative Number of PHI Requests by Type, 2020

HHS Category	HHS Percentage	AHIOS Category	AHIOS Percentage [FN1]
Individuals	50.0%	Patient-to-Self	10.9%
Health Care Providers and Health Plans	25.0%	Continuity of Care	54.2%
Third Parties Other Than Providers and Plans	25.0%	Commercial	35.0%

[FN1]: The figures in this column do not sum to 100.0% due to rounding. Source: AHIOS company data.

The problems with the HHS estimates are compounded by the application of Methodologies 1 and 2. As summarized above, for Methodology 1, HHS assumes that all requests are for hybrid records, yet AHIOS members report that hybrid records are much less common than records in a single format, such as EHRs. HHS also makes assumptions about the mixes of formats in hybrid records (*e.g.*, 100 pages of pre-EHR electronic records and 100 pages non-electronic pages)[32] without explaining the basis for the wide-ranging assumed mixes.

For Methodology 2, HHS estimates that half of the 615,000 (25%) requests directing PHI to third parties besides hospitals and health plans are TPDs for PHI in EHRs. In addition, HHS states that 307,500 of the 615,000 access requests are for hybrid records and "would no longer fall within the right of access" under the Proposed Rule. Because such requests are not TPDs under the

[29] NPRM, p. 6503.
[30] NPRM, p. 6503.
[31] There are other request types that are processed, such as those related to health care plan audits and reviews, but HHS has not included those and they are not directly affected by the Proposed Rule, so for purposes of comparison the percentages listed are calculated as a portion of these three combined request types. If those other request types were to be included, the difference between the HHS and AHIOS percentages would be greater, as there would be more requests to send PHI to "third parties other than health care providers and health plans."
[32] NPRM, p. 6508.

HITECH Act or *Ciox*, we do not read the statement by HHS to mean that the Proposed Rule narrows the right of access to exclude them.

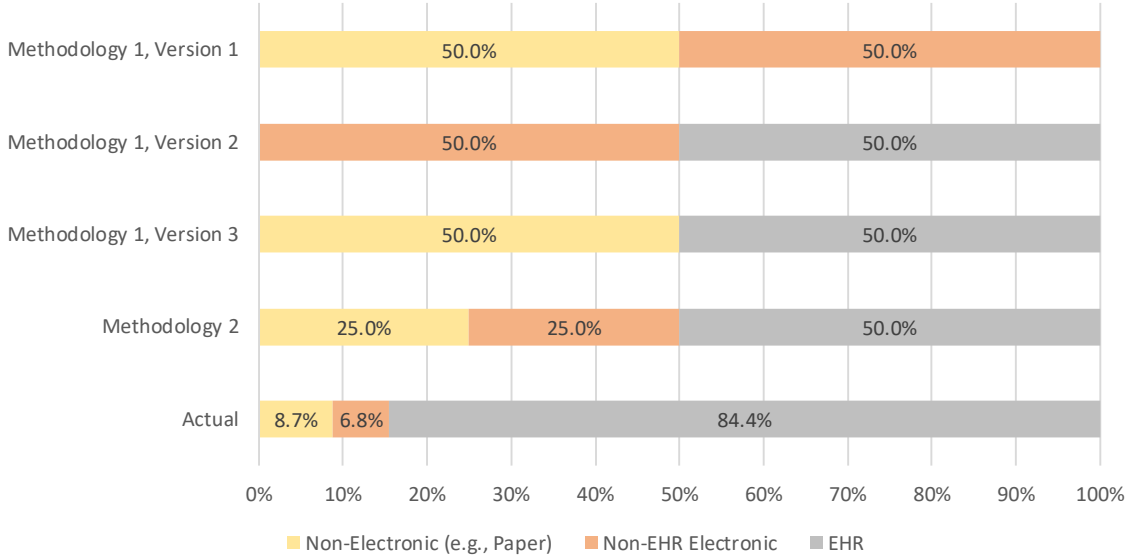
In contrast to the various alternative scenarios and assumed composition of the requests to provide Commercial (or, using HHS's phrasing, "third parties other than health care providers and health plans") businesses PHI under the Proposed Rule, data from AHIOS members from 2020 shows that 84.4% of the requests for PHI by Commercial requesters are for PHI in EHRs, with 6.8% pre-EHR electronic records, and 8.7% non-electronic:[33]

Figure 3. Requests by Type, 2020: Sampled ROI Companies

	EHR	Non-EHR Electronic	Paper	Total
Attorneys and Insurance Companies (Billable)	84.4%	6.8%	8.7%	100.0%
Reviews and Audits	87.2%	6.0%	6.9%	100.0%

The result is that more than 80% of requests that direct the transmission of PHI to a commercial third party *fall within the right of access*, and the new regulatory text would apply the Patient Rate to *all such requests*. This is far different than the scenarios postulated by HHS in the NPRM, with purported savings to health care providers.

Figure 4. Mix of Non-Electronic, Electronic Non-EHR, and EHR Records in Requested PHI



Source: NPRM, p. 6508, and AHIOS member company operational data (year 2020).

Moreover, there is trend towards EHR, given that more PHI records are being created and ported into EHR systems every day, and the non-electronic and old-electronic (which do not qualify as EHR) records represent a smaller and smaller part of this group as time passes.

[33] These percentages are based on a weighted average, meaning that AHIOS member companies with more requests receive greater weight in the average. The use of a straight average increases the percentage of life insurer and attorney requests for PHI in EHRs from 84.4% to 89.4%.

HHS assumes incorrectly that the current rule limits charges by covered entities

HHS has, without any explanation, calculated "cost savings" based on an assumption that there is a "current rule" limitation on rates that is not reflective of the state of the law or industry practice after the *Ciox* decision. Specifically, as described above, HHS assumes that there is a "current rule" limit on a 100-page electronic record request of $8.49. That is not what ROI Companies or covered entities charge for these requests when the information is sent to a Commercial Third-Party Requester. Rather, as described above, these requests follow the *Ciox* decision, which vacated the rate limits in the 2016 access guidance, leaving only requirements under the HITECH Act and state law. The actual experience of processing requests shows that requests to send information to third parties are generally billed at state rates. Because ROI Companies are already charging state rates, there can be no cost savings benefit through a future migration to such rates.

For example, HHS assumes that the current rule allows a charge of $8.49 for a third-party request of EHR records, as seen in Table 9 and described in the NPRM. But no explanation is provided for why this supposed current rate is the maximum allowable. ***HHS assumes a limit that is not actually in place***.

HHS assumes a migration to unspecified state rates

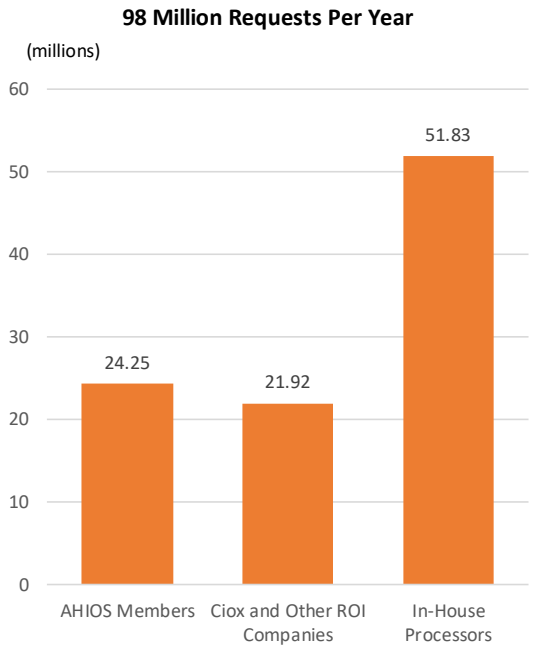
Even if ROI Companies and covered entities could begin charging state rates for access requests directing PHI to third parties, the HHS cost-benefit analysis relies on state rates that are not keyed to specific states. HHS does not explain where the rates come from, what fee components are included, or why the rates are reasonable benchmarks for all states. AHIOS members report that the state rates assumed by HHS appear to exceed those typically charged by ROI Companies (that at times grant discounts below what can legally be charged, as a courtesy).

The finalization of the Proposed Rule would apply the Patient Rate to a much larger number of access requests

The Proposed Rule reduces much more of the PHI-request revenue than the percentages estimated by HHS. The amount of this revenue reduction, as described below, is 98.1% or more on these requests, using HHS's estimated rates, which is problematic when combined with a lack of "cost savings" of the type HHS estimated without the benefit of industry data.

As can be seen in the data shown above and referenced above, not only are the percentages far off from those estimated by HHS, but so too are the numbers of requests. The figures above are for *only the AHIOS member ROI Companies surveyed* (which had 2.3 million third-party commercial requests in 2020, and 14.4 million total requests). But the survey respondents represent only 59.5% of AHIOS, which is approximately 25% of the total market, which was estimated to be 98 million PHI requests per year, based on 2018 data.

Figure 5. Annual PHI Requests and Revenue From PHI Requests and Total Addressable Market



$18.25	Average Revenue Per Request (from Sampled ROI Companies)
	x
98 million	Requests per Year (2018)
	=
$1.79 billion	Total Addressable Market

Source: Market analyst total market size estimate, based on 2018 data; AHIOS member data and estimate.

If one were to apply the average charge per request, from the sampled ROI Companies, to the estimated number of annual requests, the result is a total market size estimate of $1.79 billion.[34]

Viewed in total, the financial effects on ROI Companies of the implementation of the Proposed Rule would be disruptive or debilitating, as described further below.

HHS acknowledges that its cost-benefit analysis has significant limitations and suggests that it can address those limitations with more data. But more data will not make the Proposed Rule function as HHS intends, in particular because the purported "cost savings" are non-existent, while the cost increases are underestimated. The data from AHIOS members from 2020 show that the costs of finalizing the Proposed Rule would outweigh the benefits, to the point of defeating the main purpose of the rulemaking, which has been stated to be to eliminate barriers to coordinated care.

In sum, the HHS cost-benefit analysis is flawed in many respects. The assumptions made by HHS about the rates that covered entities presently charge—and would charge upon finalization of the Proposed Rule—are contrary to industry data and experience or arbitrary. The HHS assumptions about the number and makeup of the requests for PHI each year are equally counterfactual, understating the impact on ROI Companies and covered entities, as data on actual requests show. An analysis drawing on industry data and experience reveals that finalizing the Proposed Rule would reduce the revenue of ROI Companies to the point of making their current business models unworkable. Regardless of how ROI Companies and their health care provider clients might respond

[34] This estimate is based on assumptions about the mix of requests handled in-house by health care providers, and the frequency with which in-house fulfillers of requests waive fees. Also, this is this is an estimate based on 2018 data. The 2020 data that was used to calculate the $18.25 per request rate included a period when the 2016 access guidance was in place.

to such a sweeping structural change in the industry, the end result would still be a massive shift of health care costs to health care providers and eventually individuals and government payors.

3. COST SHIFT ESTIMATION BASED ON AVAILABLE DATA

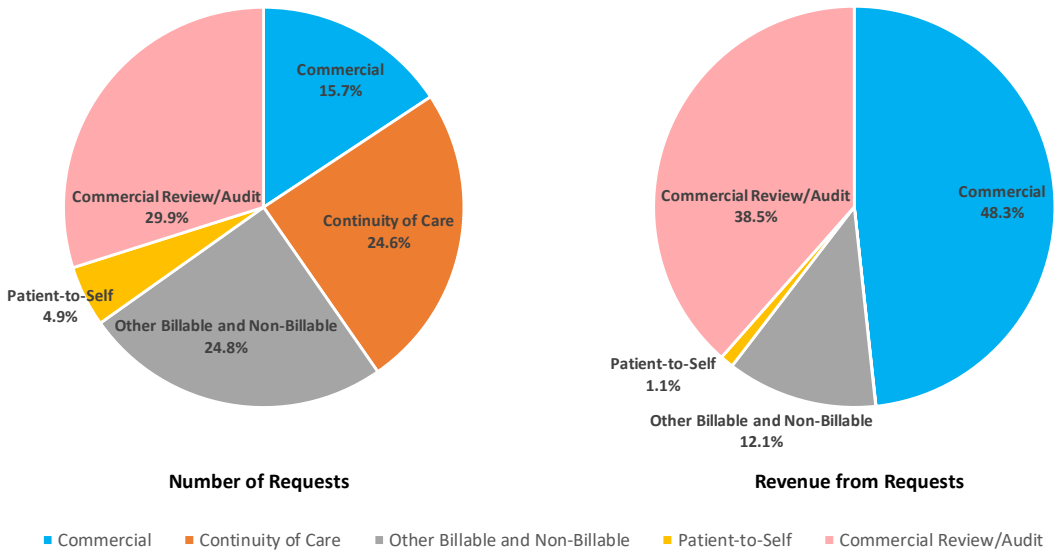
a. THE FEES PAID BY COMMERCIAL THIRD-PARTY REQUESTERS SUBSIDIZE THE RELEASES OF PHI THAT ENABLE CARE DELIVERY AND COORDINATION.

As described above, under current federal and state laws, ROI Companies must charge some requesters rates that do not cover the costs of fulfilling requests for PHI. The costs per request include items such as:

- Compensation and related expenses for people handling the requests (*e.g.*, wages/salaries, workers' compensation insurance, taxes, office space), who include:
  - Individuals collecting records;
  - Individuals processing, analyzing, validating, and transmitting records; and
  - Individuals managing the system and process, including studying and staying current on rules and regulations in different states and under federal rules, across several request types; plus
- Computers, systems, and related costs incurred to collect, store, and transmit information.

The two pie charts below show that requests for PHI by Commercial requesters account for 48.3% of revenue, and requests by Commercial Review/Audit requesters account for 38.5% of revenue. Together, those revenues cross-subsidize the free or nearly free releases of PHI to patients or providers that actually enable care delivery and coordination.

Figure 6. 2020 Volume and Revenue From Patient Data Requests: Sample ROI Companies



Source: Company accounting records.

For example, Commercial requesters generate 48.3% of the revenue from 15.7% of the requests, while requests for Continuity of Care generate no revenue but represent 24.6% of the requests. Again, the revenue from Commercial and Commercial Review/Audit requests subsidize the free or nearly free releases of PHI to patients and their health care providers that enable care delivery and coordination.

b. THE UNINTENDED YET LIKELY CONSEQUENCE OF FINALIZING THE PROPOSED RULE IS A SIGNIFICANT COST SHIFT TO HEALTH CARE PROVIDERS.

The data from the AHIOS member companies from 2020 are the most relevant data for projecting the likely consequences of finalizing the Proposed Rule as written. Those data show that, as described above, the number of TPDs rose by over 1600% from 2015 to 2019 at AHIOS member #5, as Commercial Third-Party Requesters realized they could reduce their costs by seeking records through TPDs instead of patient authorizations (and grew from nothing to a significant part of the requests for others). This correlated with the issuance of the 2016 access guidance. Then TPDs fell to almost none in 2020, after the 2016 access guidance was vacated, as shown in Figure 1 above.

In addition, as described above, HHS has estimated that 25% of all access requests will direct PHI to third parties besides health care providers and payers. As explained above, Commercial requests are 35% of the total access requests within AHIOS categories of Patient-to-Self, Continuity of Care, and Commercial requests. If Commercial Third-Party Requesters rapidly jump to TPDs to reduce their costs, it would shut off the revenue that cross-subsidizes the free or nearly-free release of PHI that enables care delivery and coordination.

With the elimination of revenue to keep the current system in place, health care providers would have two choices: take this function in-house, or change to a pay-per-request model that would compensate ROI Companies for their time, investment, and effort. Either way, health care providers would bear the burden of the cost, as the vast majority of the Commercial requests are TPDs, and the Commercial Third-Party Requesters that have paid state rates since *Ciox* would have the opportunity to access the lower Patient Rate after finalization of the Proposed Rule.

The cost shift from the loss of just the revenue derived from fulfilling requests for PHI by Commercial Third-Party Requesters would be fatal to the current business model under which cross-subsidization pays for the system. This is observable from a review of the 2020 income statements for the ROI Companies investigated, which are estimated to represent 59.5% of the AHIOS membership, by revenue. The average operating margin (earnings before interest and taxes) for those ROI Companies is 14.1% of sales, while the average net income is 1.8% of sales.[35] If ROI Companies were to lose anywhere close to 48.3% of their revenue, their margins would quickly run negative and they could no longer pay for their expenses to respond to requests, let alone make a profit, under their current business model. The same experience would be felt by covered entities with an in-house ROI function, as they too would lose this revenue and would have to bear costs that were previously covered by revenue permitted by the HIPAA Privacy Rule.

As previously discussed (see Figure 2), 84.4% of the requests for PHI are for PHI in EHRs and, if made as TPDs, would fall within the right of access. And this percentage is growing as new health records are created in EHR systems and old records are imported into EHR systems.

[35] These are weighted averages based on size. A straight average yields similar results, with an average operating margin of 10.1% of sales and net income of 2.1% of sales.

HHS's estimates of allowable fees under its calculations indicate that a 98.1% (or more) reduction in allowable fees[36] would occur if a request moved from a request charged at the state allowable fee, to the lower capped fee per the Patient Rate under the Proposed Rule (from $76.70 down to $1.49).[37]

To estimate the likely magnitude of the cost shift, the calculation below uses the lowest of HHS's assumptions, reflecting a 98.1% reduction in allowable fees,[38] multiplied by the EHR percentage of 84.4% and the 48.3% of revenue at risk (for just Commercial requests), yielding a 40.0% reduction in total ROI Company revenue:

Figure 7. Attorneys and Billable Insurance At Risk Summary

Percentage of Revenue	48.3%	A
Percentage of Requests that are EHR	84.4%	B
Percent Decrease from Current Billing to PDR	98.1%	C
Total Exposure	40.0%	D = A x B x C

A revenue reduction of 40% would take operating profits from positive 14.1% to negative 25.9%, and make it impracticable for ROI Companies to operate profitably under their current business model, and similarly hurting health care providers fulfilling requests in-house. In response, it is likely that the vast majority of health care providers would go to a pay-per-request model with the ROI Companies, with health care providers bearing that cost, given that nearly 80% of hospitals and many outpatient health care providers have shown they value having requests for PHI fulfilled by ROI Companies. As a result, the same outsourcing is likely in the future, but with ROI Companies paid per-transaction.[39] It is likely that health care providers would eventually pass some or all of those costs on to individuals, health care plans, and government payors.

The analysis becomes starker for covered entities and ROI Companies if Commercial Review/Audit requesters and other entities succeed in accessing the Patient Rate after finalization of the Proposed Rule. As referenced above, Commercial Review/Audit and other requesters have accessed the Patient Rate in the past, and continue to do so through negotiation. It is therefore reasonable to expect that some of these requests would become costs not covered by revenues after finalization of the Proposed Rule. Below those figures are also calculated.

The dollar amount of the cost shift can be estimated by applying the percentages above to the average annual revenue derived from requests for PHI by Commercial and Commercial Review/Audit requesters. Applying the percentage distribution and average fee per request, by request type, to the total market of 98 million requests per year,[40] yields the calculations shown below (based on 84.4% of requested pages being EHR and a 98.1% reduction in fees for those requests).

[36] Using HHS's hypothetical example of allowable fees for a 100-page record for electronic pages under state law, if such a request were a TPD subject to the Patient Rate under the Proposed Rule.
[37] The reduction is greater for if the request goes to $1.49 from the higher HHS-estimated rates.
[38] In practice, it is likely that this would be a 100% reduction because it would not be worthwhile to issue a bill for $1.49 (HHS's assumed rate under the Proposed Rule). However, that would save a small amount of processing and postage costs.
[39] In fact, this model is already in place in limited instances, so expanding that model is a likely outcome. In fact, all of the interviewed ROI Companies expressed the expectation that this is a likely outcome.
[40] This estimate was made as part of a market study commissioned by a member of AHIOS. It also aligns with other data that indicate that AHIOS accounts for approximately half of the ROI Companies industry, which accounts for approximately half of the total number of requests.

As referenced above in Figure 4, the calculation of the total cost shift includes a component related to in-house request processing. The available data on request size and type are from the sampled ROI companies. As a result, it is possible that the average revenue per transaction for in-house fulfillers of PHI requests is not as high as the average for ROI Companies ($18.25 per request is the average across all requests). As referenced above, AHIOS member #5 maintains data comparing in-house collections showing that they are 40% lower than ROI Companies. As a result, the figures below also account for a 40% reduction in the average revenue per request for in-house fulfillers of PHI requests (in other words, they would lose less because they do not collect as much as ROI Companies do).

Figure 8. Revenue at Risk on Commercial and Commercial Review/Audit PHI Requests

	(millions)
Commercial	$563.6
Commercial and Commercial Review/Audit	$1,012.9

Source: Third-party market size estimate; AHIOS member data and estimate.

The figure above summarizes the risk: over $560 million in annual revenue on Commercial transactions that fall to the Patient Rate (as will happen for TPDs), and over $1 billion in annual revenue if Commercial Review/Audit requests fall to the Patient Rate.

These estimates likely understate the amount at risk and the expected cost shift because: 1) the total requests per year are from a 2018 study (and the trend has been that request volume has been increasing, as has the size of the requests), 2) EHR requests are assumed to be 84.4% of total requests, but are increasing over time, and 3) 2020 was a year that understated Commercial request volumes and fees because the 2016 access guidance was effective for part of the year, so these were coded and charged at the Patient Rate before the *Ciox* decision.

4. HEALTH CARE PROVIDERS AND PATIENTS WOULD BE WORSE OFF IF THE RULEMAKING CAUSED ROI COMPANIES TO EXIT THE MARKET.

Health care providers achieve cost savings by outsourcing fulfillment of PHI requests to ROI Companies that can achieve economies of scale and greater efficiencies. If ROI Companies exit the market or begin charging for services on a per-request basis, and health care providers bring ROI operations in-house, then it is reasonable to expect providers to experience a cost increase (on top of a cost shift) because they cannot achieve the same efficiencies and economies of scale as ROI companies.

Evidence of cost savings and efficiencies is found in client testimonials about the benefits of outsourcing to ROI Companies; samples of these have been compiled in Appendix D. Benefits cited include:

- Significant improvement in request turnaround time;
- Greater efficiency and productivity of work done by health care providers (as they no longer have to process EHR requests);
- Increased accuracy and improved customer experience for patients and other requesters of PHI (evidenced by fewer customer complaints);
- Improved compliance through standardized processes and business tools refined through multiple implementations with multiple customers by ROI Companies;
- Decreased provider staff turnover; and
- Lower costs or cost savings.

The most telling data point is the widespread adoption and use of ROI Companies by health care providers. The fact that ROI Companies have retained their health care provider customers and grown year after year is evidence that health care providers derive significant value from outsourcing to ROI Companies, and prefer outsourcing to the in-house model.

If HHS finalizes the Proposed Rule and shifts costs from Commercial Third-Party Requesters to health care providers and their ROI Companies, and that results in health care providers bringing ROI services in-house, it is reasonable to expect that patients would be worse off in terms of the quality of service and increased costs, with greater risks of mishandling of information. As a result, it is likely that patients are materially better off under the status quo because ROI Companies currently enable care delivery and coordination through free or nearly free releases of PHI to patients and their health care providers.

APPENDIX A. QUALIFICATIONS OF HEMMING MORSE TEAM

Christian Tregillis, CPA, ABV, CFF, CLP, is a partner in Hemming Morse's Los Angeles office. In this capacity he analyzes financial, accounting, economic, statistical, and market issues. In the course of his 30-year career he was worked on over 500 projects for clients, most frequently in the estimation of the economic impact of events on the financial condition of businesses and ability to earn profits. For example, he built datasets for each state in the U.S., to analyze the impact on profits of alternative pricing of drugs, per alternative government-defined prices, for a major pharmaceutical company. He has also estimated the impact of alternative contractual interpretations and pricing, both past and future, on dozens of matters. He is a Certified Public Accountant (licensed in California), Accredited in Business Valuation, Certified in Financial Forensics, and a Certified Licensing Professional. He has written, presented, and taught on business topics, including accounting, economics, revenue estimation, and discount rates, among others. Mr. Tregillis earned his A.B. in Economics with Distinction from Occidental College and his M.B.A. in Finance and Accounting from the University of Chicago. In addition, he is a past chair of the Economic Damages Task Force for the American Institute of Certified Public Accountants and chair of the Economic Damages Section of the California Society of Certified Public Accountants.

Jeffrey Klein, CPA, M.B.A., J.D. is a principal in Hemming's Morse's Los Angeles office. He has over 15 years of consulting experience analyzing accounting, financial, economic, and market issues for clients across a diverse set of industries, including retail, apparel manufacturing, health care, semiconductor, telecommunications, dental products, media, government, consumer electronics, financial services, social networking, beverage, food, hotel, and music. Mr. Klein has a Bachelor of Arts degree in Economics (cum laude) from the University of California San Diego, as well as an M.B.A. from the Anderson School at UCLA and a J.D. from the UCLA School of Law.

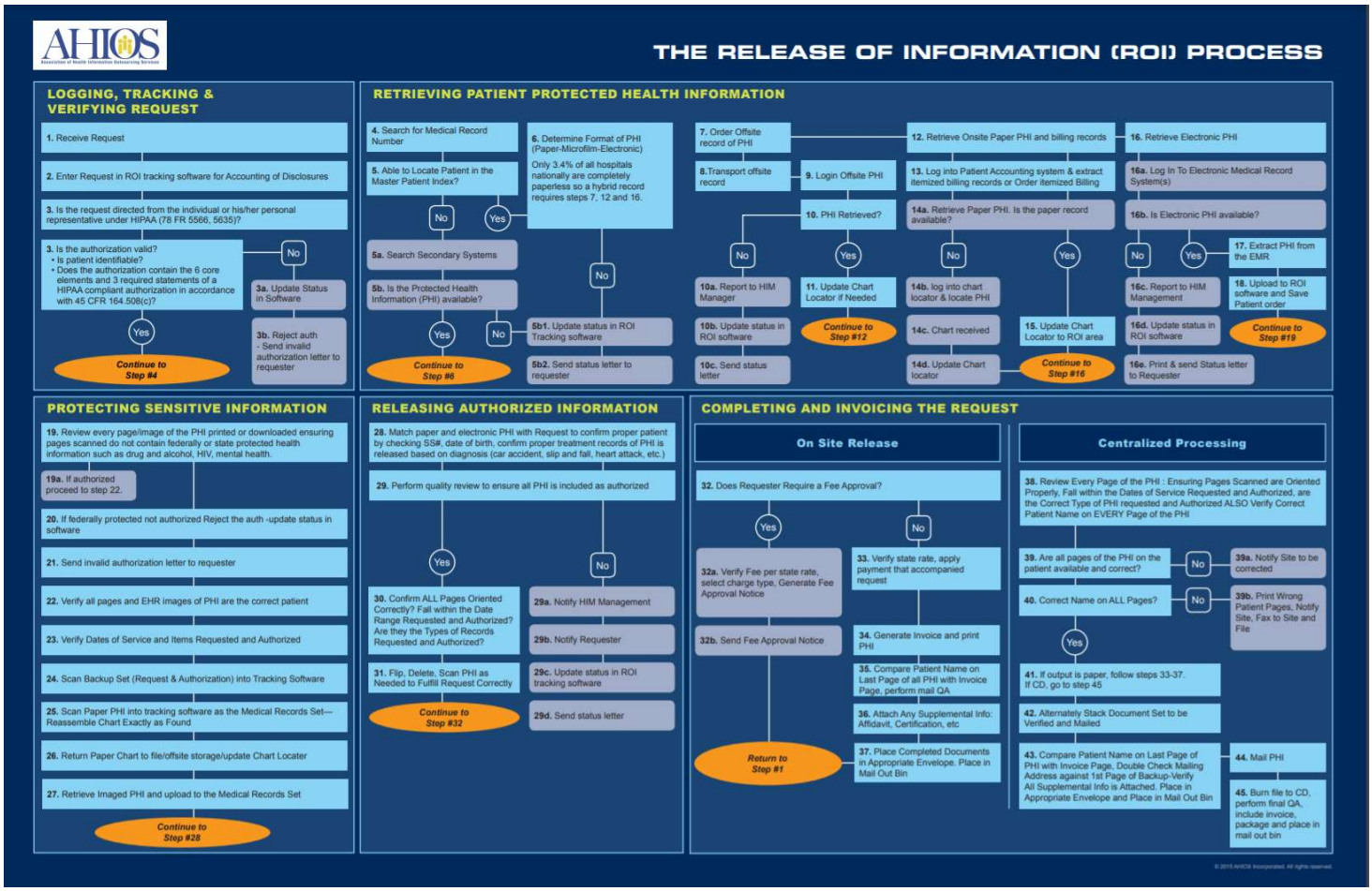
APPENDIX B. INFORMATION AND METHODOLOGY

The information and analysis reflected in this report is the result of market research, discussions with AHIOS member companies, and data and information collected from AHIOS member companies. Data and information collected from AHIOS member companies includes, but is not limited to, financial performance of AHIOS member companies (*e.g.*, operating income margin and net income margin), as well as information regarding the number of PHI requests, the type of requests, the pages per request, and the revenue associated with those requests. Where AHIOS totals are provided and identified, those represent weighted averages, based on the amount of revenue of the member companies. For example, a company that has twice the revenue, compared to another, would have twice the representation in the weighted average.

AHIOS member data were collected on a secure electronic site/data room, to ensure privacy of information. AHIOS members participating in this study, to varying degrees, based on available information, include the following:

- Acton Corporation
- Diversified Medical Records Services
- HealthMark Group
- Lexa Records
- MediCopy
- Midwest Medical Records Association
- MRO Corporation
- Record Connect
- RecordQuest
- Records Reproduction Services Medical (RRS)
- ScanSTAT Technologies
- Sharecare
- Stat Informatic Solutions
- Verisma Systems

APPENDIX C.


AHIOS
THE RELEASE OF INFORMATION (ROI) PROCESS
LOGGING, TRACKING & VERIFYING REQUEST
1. Receive Request
2. Enter Request in ROI tracking software for Accounting of Disclosures
3. Is the request directed from the individual or his/her personal representative under HIPAA (78 FR 5566, 5635)?
3. Is the authorization valid?
• Is patient identifiable?
• Does the authorization contain the 6 core elements and 3 required statements of a HIPAA compliant authorization in accordance with 45 CFR 164.508(c)?
No
3a. Update Status in Software
3b. Reject auth - Send invalid authorization letter to requester
Yes
Continue to Step #4
RETRIEVING PATIENT PROTECTED HEALTH INFORMATION
4. Search for Medical Record Number
5. Able to Locate Patient in the Master Patient Index?
No
Yes
5a. Search Secondary Systems
5b. Is the Protected Health Information (PHI) available?
Yes
No
Continue to Step #6
5b1. Update status in ROI Tracking software
5b2. Send status letter to requester
6. Determine Format of PHI (Paper-Microfilm-Electronic)
Only 3.4% of all hospitals nationally are completely paperless so a hybrid record requires steps 7, 12 and 16.
No
7. Order Offsite record of PHI
8.Transport offsite record
9. Login Offsite PHI
10. PHI Retrieved?
No
Yes
10a. Report to HIM Manager
10b. Update status in ROI software
10c. Send status letter
11. Update Chart Locator if Needed
Continue to Step #12
12. Retrieve Onsite Paper PHI and billing records
13. Log into Patient Accounting system & extract itemized billing records or Order itemized Billing
14a. Retrieve Paper PHI. Is the paper record available?
No
Yes
14b. log into chart locator & locate PHI
14c. Chart received
14d. Update Chart locator
15. Update Chart Locator to ROI area
Continue to Step #16
16. Retrieve Electronic PHI
16a. Log In To Electronic Medical Record System(s)
16b. Is Electronic PHI available?
No
Yes
16c. Report to HIM Management
16d. Update status in ROI software
16e. Print & send Status letter to Requester
17. Extract PHI from the EMR
18. Upload to ROI software and Save Patient order
Continue to Step #19
PROTECTING SENSITIVE INFORMATION
19. Review every page/image of the PHI printed or downloaded ensuring pages scanned do not contain federally or state protected health information such as drug and alcohol, HIV, mental health.
19a. If authorized proceed to step 22.
20. If federally protected not authorized Reject the auth -update status in software
21. Send invalid authorization letter to requester
22. Verify all pages and EHR images of PHI are the correct patient
23. Verify Dates of Service and Items Requested and Authorized
24. Scan Backup Set (Request & Authorization) into Tracking Software
25. Scan Paper PHI into tracking software as the Medical Records Set—Reassemble Chart Exactly as Found
26. Return Paper Chart to file/offsite storage/update Chart Locater
27. Retrieve Imaged PHI and upload to the Medical Records Set
Continue to Step #28
RELEASING AUTHORIZED INFORMATION
28. Match paper and electronic PHI with Request to confirm proper patient by checking SS#, date of birth, confirm proper treatment records of PHI is released based on diagnosis (car accident, slip and fall, heart attack, etc.)
29. Perform quality review to ensure all PHI is included as authorized
Yes
No
30. Confirm ALL Pages Oriented Correctly? Fall within the Date Range Requested and Authorized? Are they the Types of Records Requested and Authorized?
31. Flip, Delete, Scan PHI as Needed to Fulfill Request Correctly
Continue to Step #32
29a. Notify HIM Management
29b. Notify Requester
29c. Update status in ROI tracking software
29d. Send status letter
COMPLETING AND INVOICING THE REQUEST
On Site Release
32. Does Requester Require a Fee Approval?
Yes
No
32a. Verify Fee per state rate, select charge type, Generate Fee Approval Notice
32b. Send Fee Approval Notice
Return to Step #1
33. Verify state rate, apply payment that accompanied request
34. Generate Invoice and print PHI
35. Compare Patient Name on Last Page of all PHI with Invoice Page, perform mail QA
36. Attach Any Supplemental Info: Affidavit, Certification, etc
37. Place Completed Documents in Appropriate Envelope. Place in Mail Out Bin
Centralized Processing
38. Review Every Page of the PHI : Ensuring Pages Scanned are Oriented Properly, Fall within the Dates of Service Requested and Authorized, are the Correct Type of PHI requested and Authorized ALSO Verify Correct Patient Name on EVERY Page of the PHI
39. Are all pages of the PHI on the patient available and correct?
No
39a. Notify Site to be corrected
40. Correct Name on ALL Pages?
No
39b. Print Wrong Patient Pages, Notify Site, Fax to Site and File
Yes
41. If output is paper, follow steps 33-37. If CD, go to step 45
42. Alternately Stack Document Set to be Verified and Mailed
43. Compare Patient Name on Last Page of PHI with Invoice Page, Double Check Mailing Address against 1st Page of Backup-Verify All Supplemental Info is Attached. Place in Appropriate Envelope and Place in Mail Out Bin
44. Mail PHI
45. Burn file to CD, perform final QA, include invoice, package and place in mail out bin

APPENDIX D. TESTIMONIALS OF HEALTH CARE CLIENTS OF ROI COMPANIES

ROI Companies' systems and processes, focused on providing fast request turnaround times, accuracy, and cost efficiencies, have been recognized by health care providers. Benefits that health care providers identified include the following:

- Significant improvement in request turnaround time
  - "By interfacing MRO's system with our Epic ROI module and MPI, we've reduced errors and improved efficiencies—in fact, the request logging process has been cut in half."[41]
  - "By eliminating dual data entry and automating so many steps of the ROI workflow with our MRO and Epic integration, the whole process is more efficient and there is a decrease in errors."[42]
    Charlotte Walton-Sweeney, RHIT, Director of Health Information Management (HIM) for LG Health/ Penn Medicine
- Greater efficiency and productivity of work done by health care providers (as they do not need to process EHR requests)
- Increased accuracy and improved customer experience for patients and other requesters of PHI (fewer customer complaints)
  - 99.99% accuracy, with 25% increase in requests logged/hour, and 92% invoice collection at Ochsner Health System[43]
  - At Northwell, we set out on a mission to personalize the patient experience across our 600-plus ambulatory locations. Verisma helped turn our patient-firs vision into a reality. Their highly innovative platform, their ability to quickly create new ground-breaking solutions, and their true day-to-day operational partnership has allowed us to implement a process that has already improved the way we engage with our patients." *Shawn Ingram, HIM Director, Northwell Health Ambulatory*[44]
- Many prevented data breaches
- Improved ROI/HIPAA compliance through standardized processes and tools refined through multiple implementations and used with multiple clients by each ROI company
  - "Verisma's HIPAA quality assurance checkpoints are great. Being in-house, we love them because it saves us time knowing our work is going to be checked by another set of eyes. We know we're releasing the correct information to the correct requestor and the correct patient." *HIM Director*[45]
- Decreased staff turnover
  - "The enhanced technologies and services provided by MRO, along with the educated staff onsite and improved morale, provide a work environment that enables staff to perform at their best each day. Our transition was smooth and seamless for all involved, resulting in greater productivity, efficiency and quality." *Cindy Phelps, RHIA, Senior Director, TSG Business Relationship Management*[46]
- Lower cost/cost savings

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[41] *Case Study: MROeLink® Integration with Epic*, MRO.
[42] *Case Study: MROeLink® Integration with Epic*, MRO.
[43] *Case Study: Mitigating Breach Risk with an Enterprise-Wide Release of Information Solution*, MRO.
[44] https://verisma.com/resources/#verisma-reviews.
[45] https://verisma.com/resources/#verisma-reviews.
[46] *Case Study: How Carilion Clinic Realized Astounding Efficiency and Quality Improvements in Release of Information, Streamlining FTEs from 23 to 9 ROI Specialists*, MRO.

- Number of full-time staff reduced from 23 to 9 at Carilion Clinic[47]

Other examples of the benefits provided by ROI Companies are found in case studies from HealthMark Group, MRO and ScanSTAT, with selected excerpts following:[48]

HealthMark Group

How an Acute Care Medical Group Reduced Average Turnaround Time for Medical Record Release From 48 Days to Under 48 Hours

Overview

In January of 2020, HealthMark Group was engaged by one of the largest physician-owned and physician-led acute care medical groups in the United States. With service lines including emergency medicine, urgent care, and virtual health, the client focuses on building custom solutions for many of the country's most prestigious and well-respected healthcare systems.

Prior to partnering with HealthMark Group, the client had nearly 7,000 backlogged medical record requests dating back to July 2019. In-house resources for handling such requests were insufficient, consisting only of a single employee. This minimal bandwidth resulted in frustrated customers, increasingly high compliance risks, and a clogged process for releasing records appropriately.

"...the client had nearly 7,000 backlogged medical record requests..."

Approach

Partnering with HealthMark Group meant shifting all responsibilities of processing existing and future medical record requests to MedRelease, HealthMark's proprietary release of information platform. With an internal team of specialists dedicated to the client, HealthMark was able to pull all existing requests from the previous partner to clear out the backlog, all while fielding new requests.

Access to a dashboard within MedRelease grants full transparency of activity and reporting, which has allowed the client to stay informed about the status of requests. The platform's secure infrastructure also ensures that the process remains fully compliant and in adherence to federal and state regulations to safeguard PHI and mitigate risk.

Results

10K+ requests — completed in only two months, of which approximately 66% were backlogged and 34% were new

10 days — to resolve nearly 1,000 pending issues related to requests dating back to one year prior

35 hours — the current SLA turnaround time* for releasing requests, down from an average of 48 days and achieved within two months of partnership

[47] *Case Study: How Carilion Clinic Realized Astounding Efficiency and Quality Improvements in Release of Information, Streamlining FTEs from 23 to 9 ROI Specialists*, MRO.
[48] *Case Study: How an Acute Care Medical Group Reduced Average Turnaround Time for Medical Record Release from 48 Days to Under 48 Hours*, Healthmark Group; *Case Study: Saint Luke's Health System Enhances ROI Workflows, Improves Customer Experience for Patients and Other Requesters*, MRO; *Client Case Study: Baptist Hospitals of Southeast Texas*, ScanSTAT.

MRO

MRO | Case Study

Saint Luke's Health System

Saint Luke's Health System Enhances ROI Workflows, Improves Customer Experience for Patients and Other Requesters

CLIENT PROFILE

Saint Luke's Health System

- 16 hospitals and campuses plus ambulatory sites
- Epic EHR
- 4,100 monthly ROI requests

RESULTS

- ROI platform interfaces with Epic EHR
- Drastic turnaround time improvements in ambulatory setting – **four months to under 10 days**
- **Over 3,600 requester calls** diverted to MRO in first three months
- Access to responsive and expert resources
- Improved customer experience for patients and other requesters of PHI

"Throughout my experience with the company—from sales, through implementation and training, to the current operational partnership—MRO's industry experts have been accessible, responsive, communicative and eager to help. It is so refreshing that MRO cares."

Sharon Korzdorfer,
HIM Director

Background

Saint Luke's Health System (SLHS), based in Kansas City, Missouri, includes 16 hospitals and campuses across Missouri and Kansas, home care and hospice, behavioral health services, physician practices, the College of Health Sciences, and more. As the health system continues to expand, its leadership is committed to maintaining a standard of excellence and delivering the highest level of quality care. Nationally recognized, SLHS consistently receives high patient satisfaction scores.

In 2017, shortly after ambulatory was consolidated under the health system, SLHS Health Information Management (HIM) leadership recognized a need to implement a better solution for managing Protected Health Information (PHI) disclosures across the enterprise.

To ensure SLHS patients and other requesters of PHI received the highest levels of quality and customer service, HIM leadership turned to MRO, a company with a proven record of accomplishment for handling ROI in both hospital and ambulatory settings. In order to compliantly and efficiently respond to 4,100 monthly requests, the health system needed advanced technology and services.

MRO Solution

In August 2018, SLHS collaborated with MRO for PHI disclosure management after evaluating multiple national and regional ROI vendors. SLHS selected MRO based on several key factors including its dedication to clients and requesters, layers of support from responsive teams of experts, and the ability to leverage technology to improve workflow. Additionally, SLHS HIM leadership recognized MRO's reputation as a true partner to providers, delivering exceptional quality in ROI.

"Reputation goes a long way," said Sharon Korzdorfer, HIM Director for SLHS. "Sales teams can sell anything, but what I have heard consistently from my HIM peers is that MRO always comes to the table prepared to meet and exceed expectations."

After just several months of using MRO's services and technologies, SLHS reported the following benefits:

- Faster turnaround times
- High levels of accuracy
- Efficiencies resulting in the reduction of a full-time employee (FTE) and minimized overtime
- Improved customer experience for patients and other requesters of PHI

ScanSTAT

SAY HELLO TO AN EASIER WAY TO MANAGE RELEASE OF INFORMATION

ScanSTAT TECHNOLOGIES

Baptist Hospitals of Southeast Texas

CLIENT CASE STUDY: BAPTIST HOSPITALS OF SOUTHEAST TEXAS

Baptist Hospitals of Southeast Texas have found the partnership they sought with ScanSTAT Technologies for Complete Release of Information services since 2008.

THE CHALLENGE

Baptist Hospitals of Southeast Texas (BHSET) had tried outsourcing Release of Information (ROI) and had managed all operations in-house, but still believed there was an opportunity to improve.

BHSET's Director of Medical Records, describes their situation before ScanSTAT, "We had worked with other companies and ran into lots of complaints about turnaround times and poor customer service, among other things. Our clients were not happy. We brought ROI back in-house for a while and found that keeping up with hiring, training, and continuing education across multiple locations was more than we wanted to manage."

THE SOLUTION

When BHSET's Director of Medical Records heard ScanSTAT Technologies could streamline their Release of Information processes, she was curious to learn more.

After evaluating ScanSTAT's company culture and technology, BHSET realized ScanSTAT would be the perfect partner to meet their needs - without any of their previous challenges. In addition to the technology ScanSTAT offered, it was a significant bonus that ScanSTAT was willing to interview and hire BHSET's current in-house ROI employees, ensuring a seamless transition.

"We were pleasantly surprised that ScanSTAT was a whole different animal from any other vendor we had used."

- Director of Medical Records,
Baptist Hospitals of Southeast Texas

THE RESULT

The onboarding process was seamless indeed, and their Director of Medical Records noticed immediate improvements within the first week of ScanSTAT taking on BHSET's ROI operations. Within the early months of their partnership, all the previous challenges were worked out and ScanSTAT had greatly improved turnaround times.

Now, if there's a question or concern, BHSET's Director of Medical Records feels confident in finding a solution quickly. **"Would I recommend ScanSTAT? Absolutely yes!"**

If you're ready to say hello to better customer service and faster turnaround times, contact ScanSTAT at scanstat.com/demo.

Let's Make This Easier For Everyone

ScanSTAT Technologies makes it easier for hospitals, health care systems, and medical practices to manage health information. We place as much importance on privacy, security, and customer service as you do. We can assume the HIPAA liability involved in transferring information and removing the burden of reporting from your staff or supporting it as needed. Whether you are considering making a complete transition or supplementing your in-house Release of Information and Health Information Management operations, we can help.

Let's Make This Easier For Everyone — SCANSTAT.COM | 866.442.9026