

# What's New with EHR Privacy and Security?

Trisha Harkness, CISSP, CHPS

Quality Forum  
June 6, 2013



## *Getting Interactive*

Get ready to participate!

Need more caffeine?

Need to stretch?

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## Acronyms

- BA: Business Associate
- CD/DVD: Compact Disc/Digital Versatile Disc
- CE: Covered Entity
- CMS: Centers for Medicare and Medicaid Services
- EHR: Electronic Health Record
- EP: Eligible Professional
- ePHI: Electronic Protected Health Information
- FAQ: Frequently Asked Question
- HIPAA: Health Insurance Portability and Accountability Act
- ONC: Office of the National Coordinator
- PHI: Protected Health Information
- USB: Universal Serial Bus



## Getting Interactive

- True or False
  - Why?
- EHR software certified to ONC 2014 Edition standards and certification only affects eligible providers pursuing meaningful use.
  - False. Many vendors, in order to keep their marketability viable, will become certified. The 2014 Edition certification is an upgrade that will be installed by many physician clinics as part of their typical upgrade process.



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- Mentioning the encryption and security of data stored in an EHR in the Meaningful Use Stage 2 measure of protecting electronic health information is to emphasize the importance of assessing the entity's potential need to encrypt the PHI to secure it.
  - True. The intention is to "emphasize the importance of an EP or hospital including in its security risk analysis an assessment of the reasonable and appropriateness of encrypting electronic protected health information as a means of securing it, and where it is not reasonable and appropriate, the adoption of an equivalent alternative measure".



Federal Register, Vol. 77, No. 171, page 54002 & 54003



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- To attest to the meaningful use measure regarding protection of electronic health information, a security risk analysis must be conducted and the provider's risk management process must address discovered security deficiencies.
  - True. Please see CMS FAQ 7705 (<https://questions.cms.gov/faq.php?id=5005&faqId=7705>) as discussed in the presentation slides.



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- Since the United States Postal Service and other couriers are merely conduits, it is recommended to send unencrypted PHI via those services.
  - False: All media containing electronic protected health information (ePHI) – whether USB drives, CDs/DVDs, backup tapes, etc. – shipped via courier services should be encrypted.
  - The decryption key should be shared with the ePHI recipient only via a different, secure transmission mechanism.



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- If my online backup vendor receives my ePHI via a secure transmission and the ePHI stored on their servers is encrypted with a key that is known only to me (the ePHI owner), the backup vendor is considered a conduit instead of a business associate.
  - False. “[A]n entity that maintains protected health information on behalf of a covered entity is a business associate and not a conduit, **even if the entity does not actually view the protected health information.**” (Emphasis added)



Federal Register, Vol. 78, No. 17, Page 5572



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- Every business associate subcontractor that has access to my PHI is liable under the HIPAA Rules.
  - True. “[U]nder the final rule, covered entities must ensure that they obtain satisfactory assurances required by the Rules from their business associates, and business associates must do the same with regard to subcontractors, and so on, no matter how far ‘down the chain’ the information flows.”



Federal Register, Vol. 78, No. 17, Page 5574



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- Both new and existing Business Associate Agreements have a transition period deadline of September 22, 2014.
  - False: “The additional transition period would be available to a covered entity or business associate if, prior to the publication date of the modified Rules, the covered entity or business associate **had an existing contract or other written arrangement** with a business associate or subcontractor, respectively, that complied with the prior provisions of the HIPAA Rules and such contract or arrangement was not renewed or modified between the effective date and the compliance date of the modifications to the Rules.” (Emphasis added.)



Federal Register, Vol. 78, No. 17, Page 5603



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- The loss of unsecured electronic media containing 505 patient records would be considered a single violation.
  - False: Where multiple individuals are affected by an impermissible use or disclosure, it is anticipated that ***the number of identical violations would be counted by the number of individuals affected.***
  - “In the case of continuing violation of a provision, ***a separate violation occurs each day the covered entity or business associate is in violation of the provision.***”
  - When calculating the civil money penalty, consideration factors include “[t]he nature and extent of the violation, consideration of which may include but is not limited to:
    - (1) The number of individuals affected; and
    - (2) The time period during which the violation occurred”



Federal Register, Vol. 78, No. 17, Page 5584 and 5691



## Getting Interactive

- The maximum penalty for HIPAA violations for a given calendar year can exceed \$1,500,000.
  - True: “In many breach cases, there will be both an impermissible use or disclosure, as well as a safeguards violation, for each of which the Department may calculate a separate civil money penalty.”
  - “One covered entity or business associate may be subject to multiple violations of up to a \$1.5 million cap for each violation, which would result in a total penalty above \$1.5 million.”



Federal Register, Vol. 78, No. 17, Page 5584



## Getting Interactive

- Penalty example for loss of unsecured electronic media containing 505 patient records
  - Impermissible disclosure violations
    - Reasonable Cause (2):  $\$1,000 \times 505 \text{ records} = \$505,000$
    - Willful Neglect (3):  $\$10,000 \times 505 \text{ records} = \$5,050,000$ 
      - Cap of  $\$1,500,000$  would be assessed.
  - Failure to properly address encryption of electronic media for 90 days from date of violations
    - Reasonable Cause (2):  $\$1,000 \times 90 \text{ days} = \$90,000$
    - Willful Neglect (3):  $\$10,000 \times 90 \text{ days} = \$900,000$
  - Total penalty for violations of both HIPAA provisions
    - Reasonable Cause (2):  $\$505,000 + \$90,000 = \$595,000$
    - Willful Neglect (3):  $\$1,500,000 + \$900,000 = \$2,400,000$



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- Since a business associate is now directly liable for civil money penalties assessed on HIPAA violations, covered entities do not need to monitor business associates' HIPAA compliance.
  - False. “A covered entity is liable, in accordance with the Federal common law of agency, for a civil money penalty for a violation based on the act or omission of any agent of the covered entity, including a workforce member **or business associate**, acting within the scope of the agency”. (Emphasis added)



Federal Register, Vol. 78, No. 17, Page 5691



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- My contracted data destruction company needs to comply with Privacy Rules related to non-disclosure of PHI and document destruction, Security Rules related to media disposal, and general Security Administrative Safeguards.
  - True. “[S]ome business associates ... may not have engaged in the formal administrative safeguards such as having performed a risk analysis, established a risk management program, or designated a security official, and may not have written policies and procedures, conducted employee training, or documented compliance as the statute and these regulations would now require.”



Federal Register, Vol. 78, No. 17, Page 5589



## Getting Interactive

- Business associate liability for impermissible uses and disclosures of PHI under the HIPAA Privacy Rule starts when the business associate contract or agreement is executed.
  - False. “[L]iability for impermissible uses and disclosures attaches ***immediately when a person creates, receives, maintains, or transmits protected health information on behalf of a covered entity*** or business associate and otherwise meets the definition of a business associate.”



Federal Register, Vol. 78, No. 17, Page 5598





## For More Information Contact

Trisha Harkness, CISSP, CHPS  
Kansas Foundation for Medical Care, Inc.  
2947 SW Wanamaker Dr.  
Topeka, KS 66610

Email: [tharkness@kfmc.org](mailto:tharkness@kfmc.org)

Phone: (620) 874-8034

Linked In:

<http://www.linkedin.com/pub/trish-harkness/5/b3/410/>



This material was prepared by Kansas Foundation for Medical Care, Inc. as part of our work as the Kansas Regional Extension Center, under grant #90RC00031/01 from the Office of the National Coordinator, Department of Health & Human Services.

